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Still a fine mess? Local government and the NHS 1962 to 2012

Article (Accepted version)
(Refereed)

Still a Fine Mess? Local government and the NHS 1962 to 2012[1]

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Abstract

Purpose – The purpose of this paper is to take 'a long view' of initiatives taken to promote integration between local government and the NHS with the objective of seeking to understand why they have achieved consistently disappointing results.

Design/methodology/approach – The paper's analysis is based on a historical overview drawn from official documents and empirical research from the time of the creation of the NHS in 1948, but primarily focussing on the principles shaping the separate but parallel reorganisations of 1974 and their continuing influence up to and including the current White Paper, 'Liberating the NHS', and the Health and Social Care Bill.

Findings – The fundamental sources of integration barriers today lie in the foundational principles of basing (a) their responsibilities on the skills of providers rather than the needs of service users and (b) their organisational forms on separation rather than interdependence   with national uniformity driving the NHS and local diversity local authorities. In addition, frameworks for integration have been established on a paradigm of seeking to build bridges at the margins of organisations rather than seeking to interweave their mainstream systems and processes.

Research limitations/implications – Future empirical research will be necessary to establish whether the currently proposed arrangements for integration do, in fact, experience the same limited results as previous ones.

Practical implications – Local and national strategies for improving integration should be reviewed in the light of the understandings set out here and local frameworks should seek to align and integrate mainstream systems and processes so far as possible. A thorough and dispassionate analysis should conducted of whether a free-standing, single purpose, national organisation still provides the most appropriate structure for delivering health services in light of changing needs, care models and resources.

Originality/value – The paper provides offers a distinctive analysis of the possible causes of disappointing outcomes from successive attempts to improve integration. If accepted it

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[1] This paper was one of a number commissioned for a special issue marking the 20th anniversary yof the Journal of Integrated Care (Vol. 20 No. 2, 2012, pp. 101-115)

could lead to a radically different approach, first, to integration and, ultimately, to the nature of the NHS and local government.

Introduction

Anniversary issues of journals are opportunities for taking the long view. In fact, they more or less demand a perspective which at least corresponds with the anniversary in question (twenty years in this case). Thus they prompt us to look beyond the here and now; to seek to understand the roots of current policy predicaments; and to assess achievements against more distant baselines. This article adopts such an approach. It concludes that that not only are many of today's barriers to integrating the NHS and local government still shaped by decisions made significantly more than twenty years ago; but that relatively little has been achieved in the various attempts to overcome them. 'Islands of good practice' have generally been identified at different points and had their time in the sun. The closure of long stay hospitals and re-provision of their services in community-oriented settings also owed more than a little to the joint efforts of the NHS and local government in some if not all localities. Taking the long view, however, it is the persistence of problems and barriers, punctuated by the successive re-launches and re-branding initiatives to improve the range and results of inter-relationships between the NHS and local government which provide the markers of a journey that, in terms of mainstream practice, has never got far beyond base camp.

By some chance, or twist of fate, the time of writing this article (January 2012) coincides precisely with another anniversary. It is fifty years to the month since the then Ministry of Health (1962) published the first ten year plans for hospital building in England and Wales. At the same time, a Circular was sent to local authorities highlighting a section of the plan that described the development of hospital services 'as complementary to the expected development of the services for prevention and care in the community and a continued expansion of those services has been assumed in the assessment of hospital provision to be aimed at' (cited by Sumner and Smith 1969 p.43). Accordingly, local authorities were asked to produce plans for developing their health and welfare services over the same ten year period. (At this time, local authorities still employed Medical Officers of Health and were responsible for community health services as well as children's and 'welfare' services. In a minority of authorities, health and welfare services were integrated within a single Department.

The first round of these 'complementary' plans was published the following year (Ministry of Health 1963) and we are fortunate that an independent evaluation of this first initiative in what we would come to call joint planning was conducted from the University of Glasgow (Sumner and Smith 1969). Its findings make fascinating and not unfamiliar reading, even

today. Space permits only a few examples but if the language is occasionally dated, the sentiments seem surprisingly contemporary:

Joined up and Whole Systems Planning

'the development of each service was usually considered in isolation, and it could not be said that there was an overall plan for the development of services for the elderly in any of the authorities studied' (p.348).

'In some case study authorities, health and welfare departments had discussed plans together, and in a few places health and welfare services came under the one department. However, the general impression gained was that, as one medical officer of health said: 'there is not really intelligent planning in the way of beds in old people's homes, numbers of flats and beds in hospitals........when asked how the substitutability of related services had influenced plans for his authority, he added: 'that sounds too logical, and in fact was not how it happened'. (p.208-209)

Cost shunting

'Another welfare officer described the views of his committee about the policy of expanding residential accommodation rather than hospital bed provision for the elderly: the welfare committee protested because they feel that in 1948 a certain role – with certain funds to do it – was allocated to the welfare committee, and if the role has changed – which it has – there should be a reallocation of finances as between hospitals and local authorities…… (p.308)

Inadequate funding for interdependent services

'The local authority associations …….warned that if they were not able to meet the extra expenditure needed to expand their services, the Minister's hospital plan would be imperilled' (p.308)

Disputes over poorly defined responsibilities

'Part of the reason for the lack of progress in planning for local authority services in conjunction with plans for hospitals was the large number of different authorities involved……However, it seemed that the more significant bar to co-operation was the division of responsibility without a clear-cut division of function. Too often this led to failure to develop a service because each side could argue the other should do it' (p.310)

Structures instead of Purpose

> 'In all the debates about reorganising the structures of central administration, local government, health services, social services and finance, the first need is to decide what it is hoped to achieve by the changes to be made. Then and only then, can useful discussion take place on how to achieve it. If it is hoped to achieve more effective planning for the health and social services it is doubtful how far structural changes of the kind being discussed will help to achieve this aim. Many of the suggested changes might well help to achieve the aim of more of more efficient administration, though even this may be doubted'. (p.371).

Single Assessment and Information Systems: Recommendations

> The possibility of introducing a unified records system…………also deserves consideration. The advantages…….would be that staff dealing with a referral for help would be able to check quickly whether other services run by different departments or different sections of the same department were already involved(p.376).

> Thought should be given to ways of ensuring that the needs of an individual old person for help are not assessed separately by a number of different people…… (p.376)

The study's findings were almost certainly predictable given that the need for more effective planning and coordination between the different arms of the NHS had become the dominant driver of proposals for what became the its very first reorganisation in 1974 (Porritt 1962, Ministry of Health 1968 and DHSS 1970. Complaints about cost shunting by hospitals went back even further, at least as far as 1951 (Parker 1965 pp. 114-118) while the very first public inquiry into the costs of the NHS had concluded that 'a more important cleavage than the division of the NHS into three parts, is that between hospital services and social care services'(Guillebaud 1956). The barriers to integration can be said, therefore, to be systemic, rooted in the foundations of the NHS and the shifting division of responsibilities between it and local government.

The 1974 reorganisation not only failed to eradicate these problems but arguably left them more entrenched. The possibility of unifying health services within local government was briefly on the table (Ministry of Health 1968, Redcliffe Maude 1969), an option first recommended in 1909 in the minority report on the future of the poor laws. However, the course ultimately adopted was to unify health services outside local government and social services within it. This decision was based on the application of an explicit principle that services should be organised on the basis of the skills of their providers rather than the needs of their clients (DHSS 1970, Wistow 1982) This solution satisfied the aspirations of both sets of professionals and, in an era of greater professional dominance, was less

remarkable than today. The doctors continued to be suspicious of local government and the emerging profession of social work saw a base independent of medicine (Seebohm 1968) as necessary for its own professional autonomy and status. Unsurprisingly, however, the principle has proved to be a poor basis for modernised public services which put people and their needs at the centre of whole systems of care and support.

Establishing two internally unified but separate services did not eliminate the need for integration between them (nor, as experience continues to teach us, did it solve problems within them). Rather it illustrated the point that each new shuffle of the structures closes some gaps (or brings external integration in house) while opening others. In short, the 1971 Seebohm social care reorganisation and the wider 1974 simultaneous reorganisations of the NHS and local government re-defined the boundaries across which integration would be necessary while also entrenching them around authorities with different cultures, systems, professional perspectives and relationships to national government and local interests. Organisationally 'chalk and cheese' in almost every respect, they were designed around two distinct principles: national uniformity and local diversity. Like oil and water, however, (if we may switch metaphors), they were soon to prove such principles did not mix.

The experience of operating the two systems lay ahead, however, when the 1972 White Paper proposed that health services should be administratively unified but coordinated in their planning and delivery with local government. Indeed, it recognised that 'a single family, or an individual, may in a short space of time, or even at one and the same time, need many types of health and social care and those needs should be met in a coordinated manner' (DHSS 1972a Note 3(b), para 7). The 'Grey Book' on management arrangements for the NHS similarly argued that needs were not divided into compartments which paralleled administrative divisions and that 'a wide range of different services (was) required to provide a complete programme of health care, including social services provided by local authorities' (DHSS 1972b para.3.25).

To underline that this requirement was, indeed, mainstream NHS business, Brown (1975 p.142-143) calculated that 70% of NHS expenditure before re-organisation went on five categories of care which had to be planned across health and social care boundaries. Among the reasons can be identified key NHS objectives like the shift towards community care, the associated shift of priorities to so-called Cinderella groups and the changing disease burden. Lest we think the last is only a recent part of the integration debate, it is worth recognising that the consequences of an ageing society and long term 'degenerative diseases' for changing patterns of demand were being highlighted in the mid-seventies (for example Tuckett 1976) and with them the coordination of service delivery by a wide range of health and other services.

Since the NHS would continue to have substantial levels of dependence on local government, the 1973 NHS Reorganisation Act contained a number of provisions to facilitate cooperation and collaboration: health and local authority boundaries were to be

coterminous wherever possible; both kinds of authority were placed under a statutory duty to collaborate; and Joint Consultative Committees were to be established to enable authorities to fulfil their responsibilities to 'secure and advance the health and welfare' of the population and support 'the planning and operation of services of common concern'.

Like many that were to follow, these arrangements were to fall far short of expectations. As early as 1976, a 'joint finance' programme added a financial incentive to the mix precisely because JCCs had been slow to make an impact and in order to compensate for the impact on council budgets of NHS policies to reduce dependence on long stay hospitals at a time of serious financial constraint. Indeed, the official historian of the NHS was subsequently to dismiss what he called the 'cumbersome apparatus' of JCCs and their 'satellite' planning teams as having made 'a miniscule contribution and (having) proved incapable of generating any meaningful momentum' (Webster 1998).

A further indicator of their weakness is provided by the attempt in 1985, forlorn as it turned out, to turn JCCs into the 'engine room' for joint planning with their own staff and relatively modest accountability to the Secretary of State.(DHSS 1985). Soon afterwards, Roy Griffiths (1988) added his distinctive assessment, calling for an end to 'the discredited refuge of imploring collaboration and exhorting action' Instead local authorities should receive a community care grant conditional on submitting a local community care plan which, inter alia, demonstrated the engagement of the NHS through 'adequate' joint planning arrangements. The same year, the Public Accounts Committee passed its own judgement on the post 1974 arrangement: 'despite the Department's assurances about the progress made to date, we are concerned that they have not developed Joint Planning arrangements that are fully effective.

At the same time, emphasis was placed on identifying and understanding the 'barriers' to integration (for example Challis et al 1988, Hardy et al 1992). The latter specified five categories of barrier: structural; procedural; financial; professional; and those of status and legitimacy. Although this approach identified particular blockages and potential ways to address them, it also fixed attention on obstacles to integration rather than the root causes of continuing fragmentation in planning and service delivery. This way of framing the issue reflected and conceivably reinforced the imbalance between means and outcomes for which initiatives to promote integration have been frequently criticised (for example DH 1998).

The White Paper 'Caring for People' accepted that 'further efforts (were) needed to improve coordination……based on strengthened incentives and clearer responsibilities' (DH 1989), not least because collaboration had 'focussed mainly on the mechanics of joint planning and joint finance' (ibid. para 6.1). Consequently, it emphasised that the 'Government intends to concentrate on outcomes rather than machinery' (ibid. para 6.11). Less than a decade later, new ministers were expressing criticisms of the arrangements for integration in unusually strong terms: people with complex needs too often found themselves in no man's land

between services as 'quality is sacrificed for sterile arguments about boundaries..........This is not what people want or need. It places the needs of organisations above the needs of the people they are there to serve. It is poor organisation, poor practice, poor use of taxpayers' money - it is unacceptable' (DH 1998. Ministerial 'Foreword' p.3).

A package of initiatives was again proposed, including:

1.   a (nother) statutory duty of partnership;

2.   a new financial incentive in the form of a 'promoting independence' grant, in part to promote 'closer working between health and social services to try to avoid inappropriate hospital admissions or placements on discharge from hospital' (ibid. para. 3.12).;

3.   new measures to monitor, review and hold health and local authorities to account for 'the shared objectives and shared sense of responsibility....essential to delivering improved outcomes across boundaries' (ibid para. 4.53).

4.   priorities guidance for both the NHS and social services would be issued 'for the first time', making 'clear that both sectors will need to contribute to joint objectives Government has set for them' (ibid.)[2].

5.   statutory authorisation of a set of organisational 'flexibilities' comprising pooled budgets, lead commissioning and integrated provision to remove what were identified as legislative constraints on innovation, integrated care and better outcomes for users and carers (ibid. 4.7).

A national evaluation found that these last mentioned 'flexibilities' led to 'closer coordination of structures, protocols and processes' as well as less tangible changes in stakeholder understandings (Glendinning et al 2002, p vi). However, the study concluded that such gains were dependent on the pre-existence of appropriate organisational and professional cultures, including high levels of 'local trust, commitment and leadership' (ibid). In other words, these 'flexibilities' seemed to facilitate the establishment of more integrated working arrangements where the preconditions already existed but were less effective in creating those preconditions.

Since then, further rounds of critiques and 'fresh' initiatives have taken place. Care Trusts were introduced under the terms of the NHS Plan (DH 2000) and were briefly threatened by Alan Milburn as a universal solution to be imposed if integration did not improve. Few were created, the Secretary of State moved on and the current minister has dismissed them as 'an experiment which never got out of the laboratory' (House of Commons 2012). A joint health and social care White Paper was published in 2006 promising a new direction for community services: it envisaged 'much more joint commissioning between PCTs and local

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[2] This statement was incorrect: a set of joint priorities for health and personal social services had been published in 1976 and updated in 1981.

authorities' (DH 2006 p.9) based on an outcomes focussed framework for commissioning health and wellbeing, together with integrated clinical networks to ensure the delivery of joined up care and support for individuals. In addition, the Department of Health would streamline budgets and planning cycles between PCTs and local authorities based on a shared, outcome-based performance framework' and there would 'be aligned performance assessment and inspection regimes' (ibid).

A deliberative public consultation had been conducted prior to publication and the document's 'vision (was) to translate what people have said into a new strategic direction' which helped them to live more independently in their own homes and focus much more on their own well-being'. The longer term aim was even more ambitious: 'to bring about a sustained realignment of the whole health and social care system………in settings closer to home' ……….with services 'integrated and built round the needs of individuals and not service providers' (ibid p.17). To make all this possible, there would be higher growth in prevention, primary and community care than in secondary care, and also resources (would) shift from the latter to the former' (ibid.).

In practice, these aspirations were largely unfulfilled and the coalition entered government against a background in which successes were being reported in some localities but they do not appear to be representative of the wider pattern (see, for example, Audit Commission 2009, 2010, Ham 2009, Lewis et al 2010, Ham and Smith 2010, CQC 2010). Certainly there are wide variations in outputs and the use of resources (such as blocked beds and destinations post discharge) which might be expected to be more consistent if services were working together to achieve better quality outcomes and better value for money (see DH 2010 and Care Quality Commission 2010) . Moreover, a significant number of the examples are predominantly concerned with vertical integration in the NHS following the advocacy of integrated care organisations by the Darzi Review (DH 2008), though some of the latter do incorporate elements of horizontal integration with social care.

 The CQC (2010) argued that more joined up care could deliver major benefits 'reducing the reliance on high-cost hospital and residential care' (ibid.). The Audit Commission (2009) returned to the theme that the limited results secured by integration came from a focus at both national and local levels on process rather than outcomes. Consequently, it recommended that organisations should 'work closely together in order to get better value from the money available and improve services and outcomes for users……………..(but) the focus should be on outcomes and efficiency gains achieved rather than the process of partnership working or the method by which the service is financed' (ibid.).

 The same sources also highlighted the impact of turbulent external environments, especially the financial deficits in PCTs in the first half of the 'noughties' and the disruption to relationships arising from the re-structuring associated with implementing 'Commissioning a Patient Led NHS' (Crisp 2005). The latter was particularly significant given

the role in successful joint working of mutual trust and confidence built on established relationships.

As readers have doubtless noted, the wheel has almost come full circle with the publication of 'Liberating the NHS' DH2010) and the Health and Social Care Bill. Public Health goes back to the local authorities it left in 1974, though only after a fashion with all but the same amount of current funds going to the NHS Commissioning Board and a minority portion going to NHS England. The creation of Health and Wellbeing Boards (including CCGs whose boundaries should not normally cut across those of local authorities) has at least echoes of restoring coterminous JCCs. However, the new Boards are part of the corporate local authority, must produce joint strategies based on statutorily required joint needs analyses, and, in effect, certify that local commissioning plans are consistent with those strategies. The NHS is transferring £2billion per annum by 2013/14 to social care, half into the non-ring fenced general formula grant and half for 'social care which benefits health care' (shades of joint finance here). A further familiar provision is a statutory duty to work together, though without any discernible provisions for enforcement (in contrast with those specified in the Bill to ensure collaboration within the NHS between the NHS CB, Monitor and CQC). There are many more proposals to promote integration and those that resemble previous initiatives will operate in a different context, in general, and have significantly different as well as similar features to their predecessors. Nonetheless, the new framework is largely shaped, as it has been previously, within the paradigm of 'bridges between parallel organisations' rather than one of integrating mainstream systems and processes (see below). The public health experience shows how difficult it is to break out of the NHS and local government silos and avoid behaviours which seem defensive of resources and status (the latter notable in the efforts of DPHs to avoid being made accountable to Directors of Adult Social Care.

At the same time, it was possible to view the full package of proposals for integration as demonstrating substantial learning from earlier evaluations and experience (Wistow 2011a and 2011b). That possibility remains but it becomes more difficult to sustain as the tendency towards national uniformity and accountability re-asserts itself over 'local liberation', a tension which the earlier work identified.

Despite frequent citations by ministers as exemplars of integration, commissioning care trusts have experienced difficulties in continuing their role in the face of the separation of PCT commissioning and providing roles, PCT clustering and the creation of a national pattern of 'commissioning support organisations'. Torbay, probably the most cited and visited (see Thistlethwaite 2011) has thrown in the commissioning towel and concentrated on its provider functions (House of Commons 2012). Other straws in the wind include:

1. the continuing insistence on three separate but interrelated outcome frameworks for social care, public health and the NHS rather than a single unified framework.

2. the resistance to the Future Forum's proposal that HWBs should have the power of veto over commissioning plans in favour of a power to write to the relevant CCG and NHS CB.

We discuss the implications of the current proposals further below. For the present, we conclude this longer view of the history of integration by re-stating the generally held view that previous initiatives to promote integration have had 'disappointing results' (to use the 'Yes Minister' code). Yet, it must also be emphasised that forming this conclusion is not to overlook or denigrate the efforts of individuals, organisations or governments to overcome the barriers to integration. Many have genuinely sought to make a reality of their visions for whole systems change based on better balanced and integrated models of care which provide less fragmented services for individuals. We can and should celebrate their vision and applaud their endeavours. In their turn, they should also be forgiven if they recall the words of Sir Roy Griffiths (1988) and conclude that 'the Israelites, in building bricks without straw, had a comparatively routine and possible task'.

However, it is equally time to accept that those efforts have failed to deliver universal and sustained change to the everyday experiences of service users. This recognition runs through much of the current debate. For example, in their statement 'Integrated Care: Making it Happen', ADASS and the NHS Confederation (2011) recognised that 'the potential for joint working across local authority and NHS services has yet to be fully exploited. We believe there are many more opportunities to make this happen in order to benefit service users'. In its first summary report, the NHS Future Forum similarly stated: 'we need to move beyond arguing for integration to making it happen' (Field 2011, p 20).

The second Future Forum Report was also clear about the poor quality of user experiences:

'While many people told us of excellent care, we heard alarming stories, particularly from the most vulnerable, of poor access, falling through gaps between services and being unable to understand how to navigate their way through the convoluted 'system'. We heard from people who had experienced delays and come to harm. The universal feedback was that the current system is fragmented and all patients, regardless of their circumstances, want a more joined-up and integrated health and social care service, planned around their needs' (Field 2012 p.9).

The Forum's 'Integration' Workstream report catalogued a wide range of barriers and other factors responsible for such circumstances:

'Sadly, in our listening exercise across England we have been told repeatedly that the system, as it stands, often does not deliver the integrated package of care that people (with complex problems) need. It doesn't deliver their desired outcomes either. There are often wide gaps between services, particularly between primary and secondary medical care, and between health and social care. The often

inefficient and unreliable transitions between services result in duplication, delays, missed opportunities and safety risks. Designing and delivering more joined-up and patient-centred services offers the hope of improving patient experience, safety, quality, outcomes and value. We have heard about the challenges faced by the sector regulators and we know the recent scandals in hospitals, home care, and care homes will not go away if we don't change the way the system works.'

This analysis is valuable both for identifying particular problem areas or pinch points in current delivery systems and because it demonstrates that not all the reasons for poor user experiences and outcomes (such as 'recent scandals') are the result of failures in the arrangements for integration, or their absence. At the same time, it is plain that service users continue to experience basic and enduring problems of service fragmentation, notwithstanding decades of initiative and apparent commitment. The remaining question is how far the continuing influence of fragmentation is because, in effect, we have been tinkering with symptoms rather than addressing its systemic causes.

CONCLUDING DISCUSSION

The above account can only be described as a whistle stop tour of half a century of collaboration. Some important documents and events have had to be omitted for reasons of space and others may have been treated so cursorily that important nuances of intention and outcome have been lost. In addition, greater weight was given to the early part of the story than the later. This balance was intentional since our long view sought to understand the lasting consequences of decisions made at the outset of the NHS and most especially around the first reorganisation of 1974.

Two immediate conclusions stand out from the perspective adopted here. First, much has been promised but little delivered. Of course, we lack validated, quantifiable baseline and interval data from the past. Repeat studies are rare and, perhaps, a neglected opportunity among researchers. Contemporary accounts of the shortcomings of integrated care and commissioning today are just that and comparisons with earlier work may suffer from comparing apples with pears, together with changing expectations or tolerances on the part of service users, professionals or researchers. If we recognise but put to one side these problems of comparison and measurement, the fact is that people's experiences of care today is seen to be fragmented and/or delivered in suboptimal settings; and this perception continues to drive policies for better quality and cost effectiveness. Not for nothing is there a strong thread of frustration in both the Future Forum (Field 2012) and Select Committee (House of Commons 2012) reports that the talking must stop and delivery must 'this time' really begin. Even if the source and nature of people's difficulties had changed over time, the need for better integration is undoubtedly an enduring policy concern.

Second, however, the shortcomings and barriers identified over time are, in practice, not dissimilar (see the Sumner and Smith 1969 findings above; Hardy et al 1992 and Alltimes

and Varnam 2012). Among the more substantial, we can identify: planning/commissioning for individual services rather than for people and the places in which they live; focussing on integration as an end in itself, rather than a means to better outcomes; financial disincentives to providing complementary and substitute services which could deliver better value and other outcomes; imprecise and changing definitions of responsibilities and consequential cost shunting; separate and conflicting outcomes frameworks; accountability and performance systems linked to the role of individual services rather than the operation of a whole care system.

Above all, however, there are two absolutely fundamental weaknesses of the current arrangements which reflect the continuing influence of principles that shaped their beginnings. First, they were built around the skills of providers rather than the needs of users; and, second, they were built for separation rather than integration. Taking these underlying structural principles in turn, the influence of the first is reflected in the difficulty people have in navigating care systems and obtaining joined up care. Two key tests of a needs led, person centred service are:

1. ease of access and appropriateness of response: is it possible to access services by 'telling your story once' and being in control of the process rather than feeling you are being passed around a poorly understood system; and
2. once accessed, can you receive joined up care in the shape of the ''right'' services at the ''right'' time from the ''right'' person and in the ''right'' place.

The answers to both are useful indicators of how far services are operating in the interests of their users. The Future Forum findings quoted above are only the most recent to tell broadly the same story about the difficulties users experience in this respect. We need to recognise, however, that that these are not just failures of integration. They are, first and foremost, failures in service delivery which flow from care and support being structured around provider more than user interests. If we want to ensure joined up care, we need to shift the balance of power and control towards users at least as much as introduce single points of access, information sharing, single assessments and integrated care packages.

In fact, it is unclear that the latter initiatives will take root unless service delivery is built around the needs of service users and directed by them or more robustly on their behalf. Currently, it could be argued that criticisms of poor integration are misdirected and can become a cloak for wider failures to put the public at the heart of public services. On this analysis, embedding the values underpinning personalisation and self-directed support becomes an essential starting point for integrated care since they attempt to deal with the root causes of the poor personal experiences and outcomes laid at the door of ineffective integration.

 The second foundational explanation advanced above for continuing fragmentation was that the NHS and local government were designed to be separate rather than integrated. At

every point of policy choice, the ultimate decision has been in favour of separate structures, responsibilities and systems. The only location in DH for exercising unified authority over the NHS and social care is at the level of the Secretary of State. In the case of health, social care and other community services the first point of such authority is, if it exists anywhere, at the level of the Cabinet and its committees. As a result, the NHS dependence on other services may be a primary concern of the NHS but at best a secondary concern of other services, and vice versa. Integration has remained on the margins of the NHS and local government because their mainstream business was defined as delivering their individual functions. In these circumstances, integration is, by definition, an 'add on' as the story of the reorganisations of 1971 and 1974 demonstrated. The recent calls by the King's Fund/Nuffield Trust (Goodwin et al 2012) for integration to become mainstream business (like waiting list targets in the last decade) are correct in the sense of securing better value from resources currently allocated to the NHS and, thus, a more cost effective system of care. Unfortunately, no one below the Secretary of State and his Cabinet colleagues has had the responsibility or means to deliver a differently balanced care system. These limitations are rooted in the structures of the 1974 reorganisations and their functional building blocks.

Sir Keith Joseph recognised the limitations of the 1974 reorganisation when it was debated in Parliament: 'in an ideal world, the answer would be to unify the NHS within local government'. However, he described the coterminous arrangements as an attempt to get as near as possible to the advantages of such unification by creating 'two parallel but interacting structures' (Joseph 1971). His choice of words was more prophetic than he seems to have recognised. As maths textbooks certainly used to make clear, parallel lines meet only in infinity. In fact, we can argue, with the benefit of the perspective provided by path dependence theory (Wilsford 1994), that the initial decision to have separate administrative forms initiated processes of separate development which, step by step, have led them to become more different and the gap between them to widen.

At the same time, we can see that integration has been framed as the design of mechanisms to bridge that gap: to build structures which span their boundaries and introduce financial incentives both to encourage participation in those structures and funding for the products of that participation. The repeated attempts to reinforce and refresh integration, outlined above, are all basically similar because they work from a common diagnosis and prescription. In effect, successive governments have tweaked and re-fined linking mechanisms between two resolutely separate management structures. Whenever, more radical options have been considered, (for example, accountability of JCCs to central government, universal care trusts, single outcomes and performance management frameworks, or shifting significant resources between budgets) they have tended to disappear with a change of minister or gradually fade away. While the 1974 arrangements have been modified over time, their essentials have remained, therefore. Indeed, since all subsequent modifications have effectively taken the twin reorganisations of 1974 as their starting point, the balance of influences from which that settlement emerged has not only

been successful in colonising the future but its latter day representatives have kept alternative approaches off the agenda. It should be no surprise, therefore that the diagnosis of problems and search for solutions seems to have repeatedly gone round the same circle.

In an earlier article for this Journal (Wistow 2011b p.9), it was suggested that the underlying model of seeking to build bridges between what were (to mix the metaphor) hardened organisational silos was fundamentally flawed. The approach suggested there was not one of structural unification, with the consequence of creating a single ever bigger silo and the accompanying disruptive effects of another reorganisation: rather it was to accept the inevitability of structural fragmentation but to interweave and align mainstream systems and processes. In addition a different balance between vertical (national) and horizontal (local) accountabilities should be struck, compatible with securing agreed local outcomes including a single point for authorising local commissioning plans. The Health Committee has adopted a similar approach but taken it further with its proposal for a single commissioning process and a single commissioner. That person would hold all public funds for older people[3], and be accountable for using them within a unified outcomes framework to achieve better value for the public resources.

This role and accountability structure would enable the commissioner to re-allocate resources as necessary but not at the cost of de-stabilising local care systems since they would also be responsible for commissioning such provision. Dilnot (2011) noted the current allocation of these resources is suboptimal. In effect, it reflects the accretion of often unrelated national and local decisions over time taken in the absence of either local or national accountabilities for securing better outcomes for service users by managing the system as a whole. The Committee's focus on individual groups of users is also worth considering as a countervailing force to the post 1974 functional structures.

What is suggested here, therefore, is an evolutionary approach which builds on current structures but seeks to weave them together in the interests of users and their needs in the round. Much more work would be necessary to fill out the details of this approach. and many of the detailed suggestions from the Future Forum and other sources could play an important part within the integration strategy necessitated by this analysis (see Goodwin et al 2012 and Field 2012). Ultimately, however, there is a choice to be made about the role and form of the NHS: is it to continue as a stand-alone single purpose national service or is it to be part of a multi-purpose local service within the democratic framework of local government. The latter option would require important changes in the structure and culture of local government as well as health services

Not all the precedents for ever closer NHS/ local government relationships are happy ones, to say the least and the case would need to be made on the basis of good evidence and

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[3] The report proposes this model for older people because they are by far the biggest users of services but also suggests it could be adopted for other user groups.

better outcomes rather than organisational imperialism or defensiveness. The option should, however, be debated fully for the first time in half a century; and the analysis should be in terms of the best fit between structure, purpose and person centred outcomes. As the NHS increasingly shifts to a preventive role, supports strategies for addressing the underlying determinants of health, and seeks to minimise hospital admissions especially in the case of long term conditions, we need to consider afresh whether its separate structure and culture can provide the optimal match between changing needs and relatively diminishing resources. If the current model of the NHS is shown to be past its sell by date, integration with local government may be one of the more effective guarantees for the survival of its values and contributions to national wellbeing.

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