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HOPE OVER EXPERIENCE

STILL TRYING TO BRIDGE THE DIVIDE IN HEALTH AND SOCIAL CARE

Professor Gerald Wistow

Few would argue that local government and the NHS are currently working well together. The current focus for division is finance and planning, and, in particular, the Better Care Fund (BCF) and the Sustainability and Transformation Plan (STP) initiatives. This situation is ironic, as the BCF was specifically designed to promote greater integration between the NHS and local government. STPs were also expected cover better integration with local authority services, including, but not limited to, prevention and social care.

Let's take a recent example: the allocation of a further £2 billion to adult social care (ASC) over three years in the 2017 Spring Budget. At first glance, this was in fact a victory for the relationship between local government and the NHS. After all, Simon Stevens, chief executive of NHS England, had actively called, before the budget, for any additional funding to go into local government – often seen as the junior partner in the health and care system – rather than into his own organisation.

However, in practice, the extra investment in local government seems to have aggravated relationships between the two sectors. For example, the *Health Service Journal* reported that a 'very senior NHS source' had told it that hospitals needed to be 'quite lippy' about ASC using the funds to reduce delayed transfers of care (DTCs) (Lintern 2017). In response, the Local Government Association (LGA) argued for more flexibility over spending, emphasising that the role of social care was greater than that of 'easing the pressure on the NHS'.

In the event, the national guidance (NHS, DCLG and DoH 2017) said councils must help meet an NHS target of freeing up 2–3,000 hospital beds by reducing DTCs. It also suggested removing funding from poorly performing councils. This resulted in the LGA withdrawing its support for the guidance (Bunn 2017), with leading local government figures accusing the NHS of being an 'inefficient' 'dinosaur' which 'resented' the allocation of funds to councils and wished 'to control how it is spent'.

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This kind of public exchange at the highest level of the NHS and local government is uncommon. It appears consistent with the view that austerity is creating an 'integration paradox' – an environment in which the need for joint approaches is more necessary to sustain services, but is simultaneously more difficult, as budget constraints encourage agencies to place tighter boundaries around roles and responsibilities (Erens et al 2016).

Such tensions, however, are far from new. Austerity may be an immediate source of difference and dispute, but the underlying causes of the current shortcomings

of integration are much deeper and historically located. Indeed, the present day divisions have their roots way back in the Attlee government's decision to back Bevan's plan for nationalising hospitals over Herbert Morrison's proposal for a comprehensive local government service.

Since then, bridging the divide has been a persistent theme of local government and NHS politics and reform. The history of the term 'DTC' provides an instructive example of just how deep-rooted these tensions can be. Adopted only recently as a supposedly less pejorative description for 'bed blocking', 'the latter had been in use since the early fifties when such patients were also referred to (even more pejoratively) as 'frail ambulant' and 'disposal problems' (Gorsky and Mohan 2001).

Even then, such difficulties were laid at the feet of the now familiar combination of increasing numbers of older people seeking hospital care and the failure of local authorities to make sufficient provision outside hospital. Yet councils saw little reason to develop services to reduce demand on hospital services that had been removed from local government in 1948 (Parker 1965). Nonetheless, from 1957 the NHS went ahead with implementing a national target that implied reductions in bed numbers for older people but with 'little concern' for doing so 'in line with the development of... new... rehabilitation and home care services (Bridgen 2001).

The link between hospital bed numbers and the development of community services became explicit with the publication of the first national hospital plan of 1962, which was combined with a call for councils to align their plans with those for local hospitals (Sumner and Smith 1969). However, the findings of an independent evaluation of those local authority plans have a very contemporary feel, as the following examples demonstrate.

- '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.'
- '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 (older people) in any of the authorities studied' (ibid).

As the above account demonstrates, there are apparently strong parallels between the NHS and local authority relationships in the 1950s and 1960s and the situation today. Such parallels are the more striking when it is recalled that formal integration mechanisms were embryonic at best in the former period. Since the 1974 re-organisation, there has been a long procession of initiatives (Wistow 2012) to promote integrated working through statutory requirements, financial incentives, formal planning arrangements and service delivery based on multidisciplinary teamwork.

“Since the 1974 re-organisation there has been a long procession of initiatives to promote integrated working... Yet these initiatives have been followed by an equally long procession of academic studies and official reports charting their shortcomings”

Yet these initiatives have been followed by an equally long procession of academic studies and official reports charting their shortcomings. For example, early in the Coalition government, the Commons Health Committee concluded that 'little by way of integration has been achieved over this 40-year period' (House Of Commons Health Select Committee 2012). The Coalition's re-launch of integration has fared no better, with the National Audit Office concluding in 2017 that 'nearly 20 years of initiatives to join up health and social care by successive governments has not led to system-wide integrated services'.

This view does not mean progress has been absent. Every period has had its poster children of good practice, such as Torbay in the recent past (Thistlethwaite 2011). But progress has been largely confined to such perceived islands of excellence, and has rarely been mainstreamed or sustained. Can the history of integration help us to understand some of the reasons for this apparently consistent failure to establish and universalise integrated care systems?

An examination of the different programmes for integration from 1974 onwards reveals that they are located within the same collaboration or partnership paradigm. The framework applied in 1974 has been re-worked in part or in whole on a number of occasions – and most recently reset in 2013 as part of the Lansley reforms. Common elements have included:

- exhortations reinforced by statutory duties to collaborate (but limited appetite for enforcement)
- shared geographical boundaries for NHS and local government (with varying degrees of (mis)alignment over time)
- local statutory forums for the coordination of planning and commissioning by individual agencies
- financial incentives and pooled budgets
- identification and spread of good practice, often through local pilot projects.

This approach is based on the compromise adopted in the design of the 1974 re-organisations. The then Secretary of State, Sir Keith Joseph, told parliament that while ‘in an ideal world, the answer would be to unify the NHS within local government’, he was proposing to get as near as possible to the advantages of unification by creating ‘two parallel but interacting structures’ (Joseph 1971).

The mechanisms identified above are, therefore, part of a partnership paradigm that has focussed on building bridges between siloed organisational structures rather than integrating their mainstream decision-making processes. The maintenance of separate outcomes and regulatory frameworks for CCGs, NHS providers, public health and adult social care are significant constraints on the extent to which commissioning and service delivery can be integrated locally, for example.

Moreover, more fundamental change has been resisted at the centre. For example, as part of the Lansley reforms, Health and Wellbeing Boards (HWBs) were established at the level of each ‘top tier’ local authority to promote integration but without decision making powers over commissioning plans. The government-appointed ‘Future Forum’ recommended that the HWBs should have such powers. This call was echoed by the Health Select Committee who argued for the creation of ‘a single commissioning process, with a single accounting officer, for older people’s health, care and housing services in their area’ (House of Commons 2012) – akin to what has since been put in place in Greater Manchester). However, the government did not agree that divided commissioning responsibilities were a barrier to integrated services (Secretary of State for Health 2012).

“The latest attempt to overcome these problems - STPs - demonstrate how little progress has been made, with local government critical of the whole approach”

This confidence now seems misplaced. The latest attempt to overcome these problems – STPs – demonstrates how little progress has been made. Local government is critical of the whole approach, seeing it as ‘all about NHS bodies and financial control, with local authorities a sort of optional add on... when

a whole system solution remains the answer' (Sinnot 2017). The Manchester devolution experiment may be the most far-reaching – and amicable – integration initiative in England so far (by some way). Its model of, in effect, combining the STP and devolution deal may merit wider consideration, but policy makers on all sides will have to work hard to overcome the long legacy of failure in this field.

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