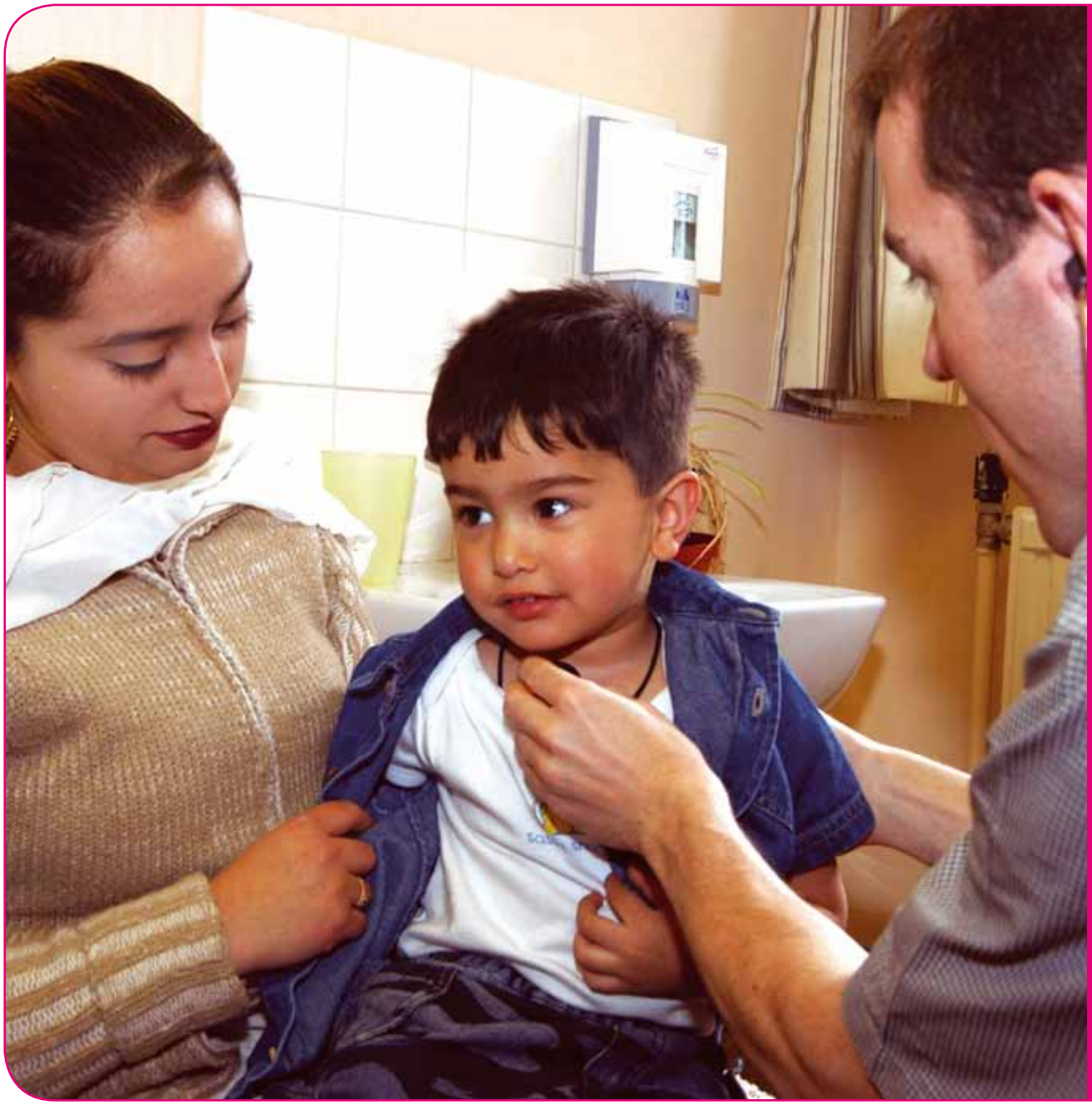
Local Government Association



Community wellbeing

Integration this time?

Liberating the NHS and the role of local government

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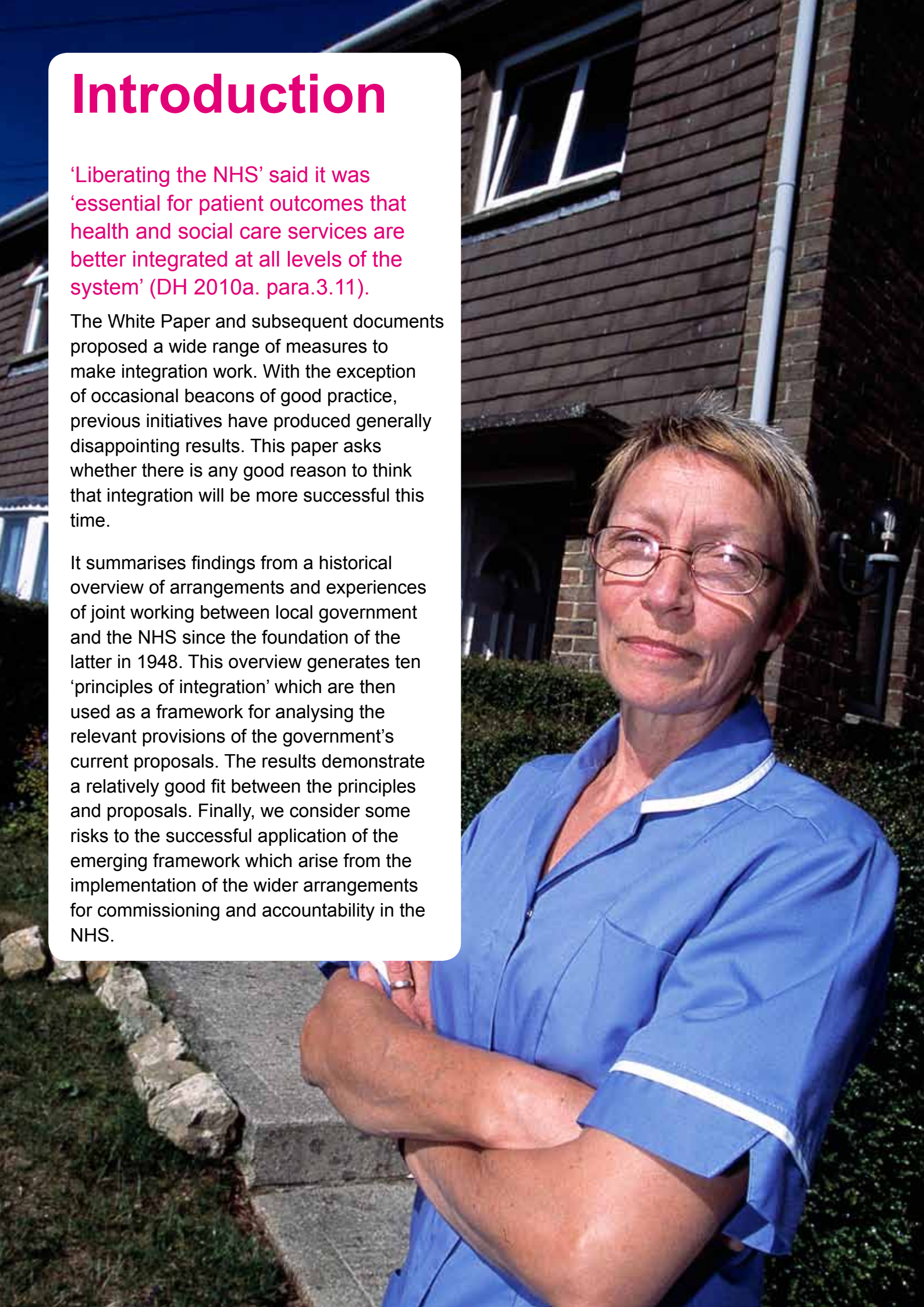
Introduction

‘Liberating the NHS’ said 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).

The White Paper and subsequent documents proposed a wide range of measures to make integration work. With the exception of occasional beacons of good practice, previous initiatives have produced generally disappointing results. This paper asks whether there is any good reason to think that integration will be more successful this time.

It 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. This overview generates ten ‘principles of integration’ which are then used as a framework for analysing the relevant provisions of the government’s current proposals. The results demonstrate a relatively good fit between the principles and proposals. Finally, we consider some risks to the successful application of the emerging framework which arise from the implementation of the wider arrangements for commissioning and accountability in the NHS.



Executive summary

Principles of integration

There is no single silver bullet for successful integration: the search for single causes has tended to lead to over-simplistic solutions dealing with limited aspects of inter-dependencies between local government and the NHS.

Expose the question to which integration is believed to be an answer: integration is not a self-evident good in its own right but a means for achieving pre-specified ends. Definitions and understandings of integration (and related terms) vary widely and thus continue to create confusion about purpose and focus.

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.

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.

The NHS and local government operate from hardened silos because that has been a fundamental and intended characteristic of their basic 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.

Because the barriers to integration are systemic in organisations designed for separation rather than integration, the historic paradigm 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.

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.

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 producing specified outcomes.

Responsibility for initiating, supporting and progressing horizontal mechanisms should be located in a single organisation to ensure it does not fall between potential partners: this responsibility is an aspect of the convening and place-making roles of local government.

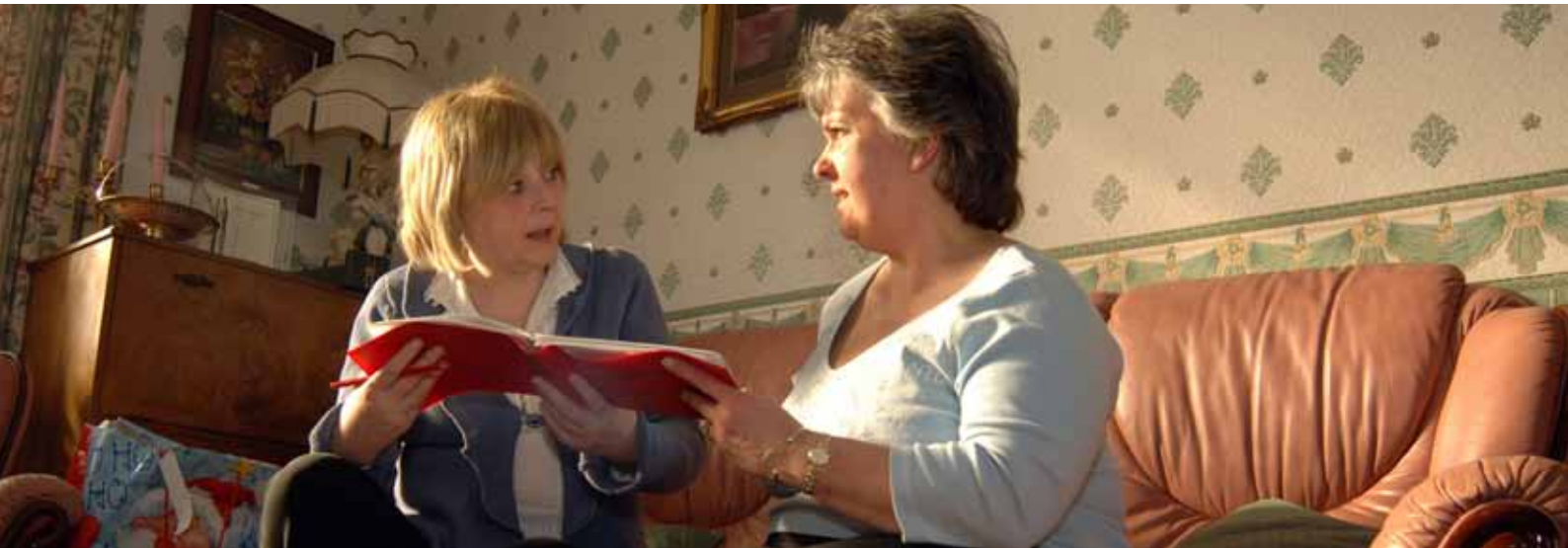
There is no single silver bullet for successful integration: sophisticated national and local leadership is called for to understand these lessons from past experience and to develop them into a coherent framework and operate it as an interlocking whole.

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 can be offered as an analytical tool informed by empirical understanding of history and practice. Moreover, when deployed alongside the current proposals, we can see a significant degree of consistency between principles and proposals (Table 1).

These similarities do not guarantee more successful integration and the delivery of better outcomes, however.

First, the Government has recognised that legislating for change 'is not at all the same as making change happen: it is a necessary step, but insufficient' (DH 2011b, para.5.49). Rather, it has described the NHS and public health reforms as being about 'wholesale long-term cultural change'. Second, some potential difficulties are surfacing as preparations for implementing the NHS changes continue to evolve.

One emerging difficulty is the tendency for transition management to focus on internal agendas as suggested, for example, by the creation of PCT clusters and the wider disruption to established personal relationships and joint arrangements including Care Trusts. The establishment nationally of separate NHS and local government transition boards conveys its own message when some form of joint transition arrangements are needed locally to compensate for the known disruption created by restructuring. Similarly, the formation of separate pathfinder schemes for GP consortia and Health and Wellbeing Boards (HWB) has a certain, pragmatic logic but also does insufficient to help re-build relationships and understandings to support integration: nor does it begin to create the local conditions for implementing the integration arrangements as a coherent and locally tailored whole.



Another emerging problem is uncertainty about the balance between the responsibilities of the National Commissioning Board (NCB) and the autonomy of local GP consortia. The reference by the future Chief Executive of the NCB to "Stalinist" Whitehall controls being needed 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' (Nicholson, 2011). In addition, the requirement for the various parties merely to write letters to each other about the extent to which they 'taken account' of others' commissioning plans, mandates and needs analyses could further undermine councils' responsibility to secure the alignment of local commissioning plans.

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 at the point of writing and much will depend on the outcome of this task. However, the balance between vertical and horizontal influences locally remains critical to the improvement of integration and better outcomes for people and places.

At present, the prospects for transforming both central/local and, therefore local/local relationships look less positive than they might and councils risk being left with bigger responsibilities but insufficient resources of power and influence to fulfil them.

Finally, the issue of financial resources must be faced. Some might argue that the integration proposals hold great potential and could be successful if it were not for a financial climate that is likely to drive protectionism. Others would 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. The end result will depend on the balance of understandings, perceptions, interests and other motivations.

Getting that balance right calls for early and intensive joint transition programmes locally, supported by a national willingness to refine 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.

Table 1: principles and proposals

Principles of integration	'Liberating the NHS' proposals
There are no silver bullets	Comprehensive package of measures potentially covering whole policy and practice interface between local government and NHS.
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?
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.
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 operate interdependently and as a coherent whole.
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.
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 eg health and social care NICE standards, joint personal data systems.

Effective personal relationships are critical but are undermined by restructuring	Explicit recognition of the importance of personal relationships and behaviours together with need for supporting incentives. Final nature of local incentives (and sanctions) is still being determined. Restructuring/transition processes will and already are undermining established relationships.
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 provide single points for potential alignment of commissioning for interdependent activities though not for approval and resource allocation.
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.
There are no silver bullets	Transition management nationally appears to be more organisation-based with limited cross-representation from local government to NHS and vice versa eg separate Transition Boards and Pathfinders. There is an apparent absence of integrated, holistic implementation programme and support locally.

Liberating the NHS and the role of local government

Liberating the NHS considered it 'essential for patient outcomes that health and social care services are better integrated at all levels of the system' (DH 2010a para. 3.11). In addition, it sought to strengthen democratic legitimacy in the NHS through an extended responsibility for local authorities to promote the joining up of local NHS services, social care and health improvement (ibid. para. 6). This paper assesses whether integration between health and local government might deliver better outcomes following the enactment of the Health and Social Care Bill 2011. The logic underlying this question is straightforward. Repeated attempts have been made to secure more fruitful relationships between local government and the NHS by creating statutory frameworks to overcome barriers to joint working and bridge the boundaries between them. A historical review conducted to support this paper (Wistow forthcoming) showed that that they had been largely defeated by fundamental blockages and barriers.

Individual examples of apparently good practice periodically illuminated the landscape but the overall pattern was broadly unchanged: the territory between two great public services remains a relatively barren no man's land in which individuals suffer the consequences of insufficiently joined-up care and support. In addition, the islands of good practice seem constantly threatened as organisational change in one or other service threatens the continuity on which the essential relationships of mutuality and trust depend.

Against this background, the White Paper envisaged local authorities would have 'an enhanced role in health' as a result of 'greater responsibility in four areas:

- (through Health and Wellbeing Boards) 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; and
- leading on local health improvement and prevention activity' (DH and CLG 2010 para.10)

Although these provisions and the associated introduction of greater local democratic accountability were the most substantial individual initiatives Liberating the NHS and associated consultative documents also included a wide range of more operational measures designed to improve integrated working 'right along the care pathway - from prevention, treatment and care, to recovery, rehabilitation and reablement aimed to strengthen integration in many other ways' (DH and CLG 2010 para.20). The following were particularly identified:

- 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)

Following public consultation, the government confirmed that better NHS commissioning arrangements were insufficient by themselves '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). It also announced that it would significantly strengthen the role of health and wellbeing boards(HWBs) and enhance joint working arrangements through a new responsibility to develop a "joint health and wellbeing strategy" (JHWS) to which local authority and NHS commissioners would be required to have regard (DH 2010b para. 1.13)

Given the history of integration, it is not unreasonable to question whether these new arrangements will produce any better results than earlier ones.

The scale and ambition of the coalition government's overall proposals are largely untested and the financial context is one in which organisations and professions might be predicted to depend their own interests rather than forge external alliances. Yet, notwithstanding the historical record and the current context, there are grounds for some optimism. Perhaps more by chance than design, 'Liberating the NHS' is introducing a number of initiatives which, together, could create the most promising architecture for the 'integration' of both governance and service delivery since the either the foundation of the NHS in 1948 as a service largely independent of local government or the subsequent reorganisations of 1974 which completed the process of creating two separate administrative entities (Wistow 1982).

An essential argument in our historical account was that previous frameworks for improving integration had been both partial and incompletely implemented. The obstacles to integration had not been addressed with adequately in terms of diagnosis, prescription, treatment or review - to adopt the vocabulary of the medical model. As a result, successive 'new frameworks for collaboration' had been built on imperfect understandings about the causes of ineffective integration or how they couldbe better tackled.

We referred above to the 'vocabulary of the medical model', a comment which, itself, should alert us to the existence of deeper value based differences between the two sectors. We could equally have described a similar set of processes using terminology derived from the social model, such as 'ASPIRE' (assess, plan, intervene, review, evaluate). The existence of these two vocabularies for similar processes demonstrates how barriers formed by

organisational structures, systems and processes are compounded by different understandings of need, its causation, and appropriate forms of response.

Such differences in values and culture mean that, even when the NHS and local government services appreciate the importance of working together to improve choices and outcomes, they may not be working from shared definitions of problems and interventions. Differences in culture and structure interact, therefore, to produce complex barriers to integration. A related difficulty is the absence of agreed definitions of the term 'integration', itself (Kodner and Spreeuwenberg, 2002; Fulop et al, 2005; and MacAdam 2008 and Lewis et al 2010). As a result, there can be at best confusion and at worst conflict about the purpose of working together and the methods to be adopted.

Integration this time? Principles and learning from 40 years' experience

Our historical review demonstrated the continuing shortcomings of integration between health and local government services together with the embedded nature of barriers between them. Ever since at least the 1962 requirement to submit local Health and Wellbeing Plans (Ministry of Health, 1963), national policymakers have sought to launch individual schemes and more complete frameworks to promote partnership working. Many have been short lived, ineffectual or patchy in their implementation. Indeed, it is striking how little has changed in relationships between the two sectors, notwithstanding the huge changes in the nature, scale and organisation of the services themselves. Descriptions of barriers from different periods of time seem almost interchangeable. Definitions and understandings of integration (and related terms) vary widely and thus continue to create confusion about purpose and focus. Some of our most vulnerable fellow citizens continue to have difficulty accessing joined up care and support. In effect, they (and their supporters) shoulder the burden of making integration work as they are referred around services 'telling their stories' repeatedly. The 'failure' of health and local government services' to ensure good experiences and outcomes is not infrequently attributable to the shortcomings of integration which the coalition government recognised and accepted.

What, then, is our basis for arguing that 'Liberating the NHS' and the associated legislative framework offer any more realistic prospects of improved integration across the whole NHS/local government interface than the narrower attempts preceding them? First, we have sought to summarise in ten principles for integration what might be learned from past experience of integration; and second, we have explored how far the current package of initiatives is consistent with those principles. This approach also enables us to identify some continuing risks arising from the potential dilution of those principles or the incomplete implementation of the new integration architecture.

Experience-based principles

The following statements are derived from the historical review conducted to support this paper:

There is no single silver bullet for successful integration: attempts to locate them are, in effect, based on a search for mono-causal explanations and individual interventions in a field dominated by complexity and uncertain

relationships between cause and effect. A multi-facetted framework is needed for managing complexity and uncertainty across the policy and practice interfaces between local government and the NHS, as a whole. Mono-causal explanations tend to lead to over-simplistic solutions dealing with limited aspects of those inter-dependencies.

Expose the question to which integration is believed to be an answer: integration is not a self-evident good in its own right but a means for achieving pre-specified ends. It imposes costs in time, management, reputation and funding. Failure to specify the meaning and purpose of integration can breed confusion, misunderstanding, conflict and lack of focus, all but guaranteed recipes for ineffectiveness in joint working. Four dimensions of integration are especially important to define and agree:

- The problem(s) to which integration is considered a response and the outcome(s) for end users and organisations it is expected to secure.
- The separate and distinct contributions of (i) integrated care models and (ii) integrated governance arrangements (for example (i) intermediate care and (ii) protocols for electronic information sharing by professionals or (i) models of care closer to home and (ii) systems wide resource allocation arrangements).
- The extent to which the service and governance models imply vertical and/or horizontal integration.
- The breadth and depth of horizontal integration expected and feasible in the context of national hierarchical relationships for vertical integration.

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, such outcomes have not been consistently articulated and employed as the principal drivers for integration. Rather integration structures and processes have tended to be treated as ends in themselves independently of their impact on outcomes. While means should be subordinate to ends, the former remain essential to provide the organisational infrastructures and individual competencies necessary for securing better outcomes. Just as means without ends cannot deliver better outcomes except by serendipity, so ends without means are little more than empty rhetoric. A particular example of the latter is the failure to match outcomes with financial means in terms of overall adequacy or the location of budgets (Griffiths, R, 1988).

Integration must be multi-levelled because organisations and their purposes are multi-levelled: whole systems plans and service models which are not embedded in day-to-day operating practices have minimal impact on the daily experiences of people and places. 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. The design and synchronisation of such mechanisms so that they ‘kick in’ at the ‘right’ times and places to provide the right care to the right people is an essential requirement for the effective integration of care and governance.

The NHS and local government operate from hardened silos because that has been a fundamental and intended characteristic of their basic design: other options were potentially available

but were explicitly rejected in 1948 and 1974. Consequently, 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 (Wistow, 1982). If their organisational routines are centred on the needs and interests of separate professions and organisations, it is because they were built that way. These organisational features are inconsistent with contemporary requirements for person-centred and place-based working, or for managing the interdependencies of organisational systems and individual needs. This view is reinforced by the changing nature of the policy and practice interfaces between health and local government. Traditionally focused through social care, the growing emphasis on prevention, early intervention, social inclusion and social capital is extending that interface to include a much broader range of council activities and functions.

Because the barriers to integration are systemic in organisations designed for separation rather than integration, the historic integration paradigm is inherently flawed and of limited effectiveness: building bridges and other boundary-spanning behaviours can help the flow between organisations, but only if the route across the bridge/boundary is not blocked at either end and the flows can be absorbed at their intermediate and final destinations. In other words, there has to be a degree of interaction for which, as has been evident for some decades, parallel organisations are fundamentally unsuited.

However, the metaphor of creating parallel organisations, as advanced by Sir Keith Joseph in the early seventies, is not entirely redundant. If parallel lines meet only in infinity, it follows that their direction must be changed if they are to intersect or fuse together. It is, therefore, a metaphor that supports the concept of 'full' integration within a single structure. We have seen this option advanced on occasion, though it has sometimes seemed to be a frustrated political or managerial response to the difficulties of managing across the NHS/local government interface. Unfortunately, it is at best a partial solution. It pushes the need for joint working out to the new boundaries, and brings established boundaries 'in-house' where they may or may not be more manageable depending on their origins and the new organisation's capabilities. The balance of advantage needs, therefore, to be carefully examined before embarking down this road.

A better metaphor in current circumstance may, therefore, be 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. The metaphor also accommodates the notion that integration mechanisms must be located at different levels in the system if the weft is provided by:

- Person-centred assessment and self-directed support
- Community commissioning and place-based budgets
- Integrated pathway planning
- Aggregated needs analysis, systems design, priority-setting and resource allocation across the system as a whole.

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. (However, effective relationships are not to be confused with cordial relationships based on minimal challenge or change). Effective relationships can also help local actors to maximise the space for local decision-making as they negotiate their local rules of the game (Williams and Sullivan 2009) in a highly centralised (English) system of governance. Strengthening the voice of people and places in commissioning and accountability will tend to strengthen the focus on local outcomes and further extend the space created by effective personal relationships between NHS and local authority personnel.

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 producing specified outcomes. In recent decades, central government has sought both to reinforce hierarchy to achieve nationally-determined targets while simultaneously advocating more effective horizontal integration, sometimes to help achieve the same targets. Designing an appropriate mix of accountabilities through national hierarchies and local networks remains a subtle and demanding challenge. Meeting it is critical to improve care outcomes and to the design of a framework for the effective governance of integration. That, in turn, depends on there being a sufficiently mature and confident set of relationships between national and local agencies so that the centre feels able to let go sufficiently and the locality is sufficiently confident to look outwards as well as (and more than) upwards.

Responsibility for initiating, supporting and progressing horizontal mechanisms should be located in a single organisation to ensure it does not fall between potential partners: this responsibility is an aspect of the convening and place making roles of local government. Despite the previous preoccupation with joint planning and joint commissioning structures, they have not always been proactively managed, action-orientated and effectively supported between meetings. There have been limited initiatives to establish joint information and joint commissioning units at different times as well as lead commissioning arrangements in some instances. The growth of health and wellbeing or similar 'theme' partnerships within the Local Strategic Partnerships has been a useful if uneven development which demonstrates the potential of the convening role. This role is best seen as that of 'first mover' and enabler of the best use of planning and project management support rather than the principal actor in delivering such functions. Both Ham and Smith (2010) and Wistow and Henderson (2010) have demonstrated the need for such system leadership in the context of integrated care.

There is no single silver bullet for successful integration: sophisticated national and local leadership is called for to understand and build on these lessons from past experience and manage integration programmes as an interlocking whole.

Another new framework for Integration

'Liberating the NHS' and the Health and Social Care Bill 2011 offer another a new statutory framework for integration. We have suggested that it offers better prospects for success than previous ones but that how the framework continues to be developed and how it is implemented within the context of the overall NHS changes will determine the extent of its success. The following summarises the extent to which it is consistent with our principles of integration.

No silver bullet

The new framework is substantial, multifaceted and potentially extends across the full interface between the NHS and local government. It gives particular attention to social care but in theory applies to any service which might impact on health and wellbeing outcomes, as set out above. It contains a number of 'greater responsibilities' for local government.

This enhanced role for top-tier councils has become more comprehensive following the White Paper consultation. The Government decided to strengthen the role of HWBs and introduce a new responsibility to develop a 'joint health and wellbeing strategy' spanning the NHS, social care, public health and potentially other local services. Local authority and NHS commissioners will be statutorily required to have regard to this strategy in their own commissioning plans within the context of existing duties of partnership. However, it is unclear how these existing or new duties will be enforced in the event of non-compliance. By contrast, mechanisms for addressing non-compliance with other duties of integration between NHS bodies (eg the NHS Commissioning Board, Monitor, the CQC) are set out in the bill.

The question to which integration is the answer…

Integration is not unambiguously defined and the distinction between integrated care and integrated governance is not explicitly recognised. There is significant scope for confusion about its meaning, therefore, and especially between a predominantly NHS understanding of it as a vertically integrated production process and the more usual local government focus on horizontal relationships across a place or locality. Nonetheless, it is made clear (and especially in the consultation response) that the purpose of integration and its intended reinforcement is to respond to organisational interdependencies especially in the context of national policies which cannot be delivered by the NHS alone.

Balance between means and ends

The framework accepts that structures and processes have previously been treated as ends in themselves. It is also part of a wider set of government initiatives to promote localism and replace process targets with outcomes for people and places. Three outcome frameworks have been prepared (NHS, social care and public health) and the intersections between them mapped to identify areas where specific outcomes are a shared responsibility. The government's consultation response says that in designing the three frameworks, it has selected indicators that incentivise joint working. These include 'responsibility for preventing people dying prematurely' and 'ensuring that individuals recover from serious conditions requiring rehabilitation and care'.

There is scope for continuing debate about, for example, the relative importance of shared and other outcomes, the measures selected and the ability of services to prioritise and allocate adequate resources to different outcome domains. Nonetheless, not only is it clear that means should be subordinate to ends but, for the first time, comprehensive, linked outcome frameworks have been developed and the shift to an outcomes focus to drive integration appears more concrete and less rhetorical than on previous occasions.

Multi-levelled integration

This aspect of our principles has been less obviously developed or at least systematised in the public documentation to date. The role of strategic needs analysis as the foundation stone for the joint health and wellbeing strategy and the HWB's responsibility to produce the latter is specified. The logic of both the empowerment of GPs in commissioning and of self-directed support in social care is one of reinforcing the influence of bottom up, person-centred needs analysis. The interface between personal budgets in health and social care is identified as an area for integration, as is care pathway planning. The latter will need to ensure proper consideration for social as well as medical/nursing models. The emphasis should be on mapping and planning personal journeys to and through services from the perspective of service users. At least as much attention should be given to operational integration as to the integration of commissioning. At present, the former seems less fully articulated as is the necessary link between strategic commissioning and service delivery.

Care pathway development also needs to be associated with incentives for multi-disciplinary working including care networks, their management and the infrastructures needed to support them (including information sharing and exchange). The ability of high-level joint strategies to impact on the working practices of front-line staff is a further area for continuing development.

NHS and local government designed to operate from silos

Perhaps the most significant, if unanticipated, aspect of the current proposals is the extent to which they could halt and reverse the paths of separate development which were taken in 1948 and 1974. The HWBs and JHWS are the first attempts to address the local democratic deficit in the NHS for four decades. Much has also been made about the 'return of public health' to its original home in local government. However, the relocation of public health should not just be seen as a transfer of responsibilities to local government. It also provides the NHS with a role inside local government. It may be helpful, therefore, to view the combined effect of the changes in public health and local democratic legitimacy in more balanced or mutual terms: as local government and the NHS each renewing their roles in the other. Not only will councils have a legitimate role and stake in health policy but health will have a similar role and influence in local government.

The hard test of these changes has yet to come and neither triumphalism on one side nor professional preciousness on the other would be helpful contributions to the relocation and reconfiguration of public health. As we have seen, perceptions of 'take over' are to be avoided at all costs in this field. Nonetheless, the combination of HWBs, local democratic accountability and the new architecture for public health offer real opportunities for mutual influence on commissioning strategies and the erosion of the silos in which the services have operated for so long.

The warp and weft of integration

As our discussion of the previous principle demonstrated, a new approach to integration is being developed. In effect, the notion of separate organisations operating in parallel is being modified and each service is being given a role and influence in the other. Parallel structures are being modified by a recognition of interdependencies. The shift in public health responsibilities and the extension of local democratic influences constitute important elements of the weft needed to bind two hierarchically-structured services together. In addition, NICE quality standards will be developed for social care as part of model care pathways spanning health and social care. Interweaving service responsibilities and securing is fundamental to the prospects for better integration outcomes.

However, as we have argued above, much remains to be done to continue this process of interweaving at and between the various levels of the two organisations. Nonetheless, the distractions of a full integration of organisations appears to be off the agenda in favour of their 'binding together' into a comprehensive local system as was advocated in 'Putting People First'HM Government, 2007).

If integration is promoted, as intended 'working right along the care pathway - from prevention, treatment and care, to recovery, rehabilitation and reablement', (DH and CLG 2010 para 20), the pathways, themselves will become powerful tools for interweaving service responsibilities and securing better integration outcomes.

Effective personal relationships

It might be argued that effective personal relationships cannot be legislated for and that we should expect to hear little about this principle at the current stage of the legislative and other implementation processes. In practice, the government's consultation response recognises that formal structures and other mechanisms can do only so much to foster integration: ''it will be the day-to-day behaviours at every level of the system which determine how successfully services collaborate with each other and whether this leads to improved outcomes''. It also argues that 'the new role for local authorities…will help to ensure that the right behaviours are being adopted at a local level, as they promote joined-up working and look across outcomes in health and social care. As we suggest below, however, such behaviours also need to be supported by an appropriate blend of horizontal and vertical accountabilities.

Our argument here is that legislation and other central government initiatives structure the space in which such relationships are formed and structure the nature and extent of integration locally. In addition, effective relationships based on mutual trust and confidence take time to mature and require continuity to deliver. The nature and scale of the NHS changes alone are incompatible with such requirements, as previous reorganisations have demonstrated. This time they are compounded by the impact of the financial context on local public sector budgets and publicly funded employment more generally. The consequence for morale, trust, continuity and the preparedness to look outward rather than inward are one of the major 'known unknowns' of implementing 'Liberating the NHS'. However, some implications can be predicted. Some leaders

will be emphasising the opportunities for radical change created by the financial climate and there is something in this. Despite other aspects of the wider public sector governance agenda being supportive of these proposals, the deficit reduction strategy (whatever its inherent necessity, strengths or weaknesses) is almost certainly the biggest threat to their success.

Ensure things happen: the convening role

The original consultation document on local democratic legitimacy specifically referred to councils operating in their 'convening' role through the establishment and operation of HWBs. These new statutory bodies are to provide the structural framework within which statutory Joint Strategic Needs Assessments (JSNAs) and JHWS are prepared as a framework for coordinating the mainstream commissioning plans of the NHS, social care, public health and any other relevant activities. The board is to be a committee of the top-tier council which makes that authority responsible for convening it and ensuring its business is supported and progressed. Similar responsibilities exist in relation to the preparation of JSNAS and JHWS, though all relevant bodies are responsible for contributing to these functions and ensuring that they take account of their outputs in their own commissioning plans. In principle, these provisions create expectations of collaborative behaviours, structures to shape them and transparency as to whether those behaviours are present. Whether such behaviours do emerge to support the drive towards shared, person-centred outcomes depends, in part however, on the extent to which, in practice, the various parties' vertical accountabilities support and reinforce such horizontal relationships.

A significant element in the coordination of commissioning plans is likely to be the reconfiguration of hospital services locally and/or sub-regionally as part of the shift towards care closer to home. There are provisions for joint arrangements between HWBs but more substantially the JSNA and JHWS provide opportunities for local authorities, including members, to be engaged in such developments from an early stage. Again, this provision creates the possibility for more collaborative behaviours rather than the oppositional ones which tend to emerge from late engagement and a lack of transparency in the planning process.

Balancing vertical and horizontal accountabilities

Securing this balance is a further area of substantial implementation challenge. The abolition of process targets and focus on outcomes is an aspect of the 'new Localism' which potentially supports the new framework for integration. At the same time, however, at least two factors may tend to operate in the opposite direction. First, the command and control culture is deeply embedded in the NHS and a different culture may take some time to become established. Similar difficulties may exist in local government which has also been dominated by its own top-down, process-driven performance regimes. Second, doubts about the effectiveness of the proposed new NHS accountability structures have been fundamental to many of the concerns about implementing 'Liberating the NHS'. Such concerns have primarily focussed on the extent to which the Secretary of State is proposing to disengage from the day-to-day operation of the service and the risks associated with transferring commissioning responsibilities and budgets to relatively inexperienced GP commissioners.

Both these concerns combine to suggest the risk that the default position will be for commissioning to remain a top-down rather than bottom-up process and for accountability to the centre to remain strong (financial pressure reinforces this argument). We have argued that vertical performance management frameworks and other central government controls may be in tension with the creation of more effective horizontal relationships. How the National Commissioning Board treats correspondence from the HWB suggesting that NHS commissioning has not 'taken account' of the JSNA/JHWS is a substantial unknown. The response to the White Paper consultation recognises the importance of the performance management and wider accountability structures in this context and says that further work will take place. The existence of a more mature central/local government relationship (without which the enhanced responsibilities of councils in health would have been impossible) is a potential facilitator here. It is understood that this work is on-going. Its importance is difficult to exaggerate from the perspective of locally successful needs-based and outcomes-focused integration.

No silver bullet...

The programme of management and cultural change implied by this framework is both particular to meeting the shortcomings of previous initiatives to improve integration and also integral to the success of the NHS changes as a whole. We have argued that there is a better prospect for more successful integration this time and not least because its requirements go with the grain of several key elements of the government's wider programme to a greater extent than on earlier occasions.

Much remains to be done as we have begun to detail here. In particular, it is critical that all the elements of the changes which potentially impact on integration between the NHS and local government are consolidated into a single implementation programme nationally and locally, as again we have begun to do here. Everything possible should be done to ensure that more successful integration depends on implementing a complete package of change. This will mean that the implications for integration of the full change programme will need to be mapped and managed. Nationally, this role will be an important one for the LGA. Locally, the constructiveness and readiness with which councils approach the change process will be important in building the confidence of the National Commissioning Board as well as that of GPs.

Conclusion

We began by questioning whether the new arrangements for integration would be more successful than previous ones. We undertook a review of the experience of implementing previous arrangements and formulated ten principles for integration based on evidence from that review. These principles were applied to the proposals contained in the White Paper and subsequent documents and we identified a significant degree of consistency between the principles and those proposals. To that extent, we can say there is a degree of fit between evidence derived from past experience of integration and the new provisions. In fact, it is possible to demonstrate a more comprehensive fit with the latter than with earlier frameworks.

Congruence with our principles does not, however, guarantee better integration between local government and the NHS. For example:

- The ten principles are only one way of categorising the evidence from previous initiatives. They do cover themes that recur in the official and academic literatures. The analysis of those sources and the synthesis of findings are informed by the author's academic and practice experiences in this field since the mid-seventies. But the ten principles are not necessarily comprehensive and the data might be cut in different ways by different commentators. Partnership arrangements and their application is informed by the principles, implementation may diverge substantially from what currently seems possible.
- The ten principles have been designed as a framework of inter-related requirements. If the new architecture for integration is not understood and implemented as a whole, its individual elements will necessarily be less than the sum of the parts and the absence of individual parts might be critical to the success of others.

The Government has also recognised that legislating for change 'is not at all the same as making change happen: it is a necessary step, but insufficient' (DH 2011 para.5.49). Rather, it has described the NHS and public health reforms as being about 'wholesale long-term cultural change, effecting significant shifts in power and responsibility from the centre to localities, and above all, about local leadership and the forging of new and stronger relationships' (ibid.). At the same time, however, some potential difficulties are beginning to surface as preparations for implementing the NHS changes and the framework for partnership working continue to evolve.

Two are particularly significant in terms of our principles: joint relationships; and the shift of power to localities. Both are related to concerns about the scale and potential impact of the proposed change agenda. David Nicholson, himself, reminded the annual social services conference in November 2010 that "the brilliance of (the) vision…is not the determining characteristic for success… (it) is how you manage the transition. How you get from where we are

today, to where we need to be in the future'' (Nicholson 2010). He also acknowledged that ''it was no accident that during the greatest set of reforms in 2004-2005 we ended up losing control of money on the one hand and having real quality problems, in places like Mid-Staffordshire, on the other. We cannot allow that to happen (again). So the leadership role in health, social care and local government generally, is to focus absolutely on purpose''.

Relationships and transition

This review of joint working has also highlighted the disruptive effects of previous NHS restructurings on joint working. Relationships between health and local government were seriously interrupted as the demands of building new organisations predictably led to key managers mostly looking inwards and upwards rather than outwards and established communication channels were cut. Such difficulties were reinforced when councils were also engaged in reorganisations such as when the creation of separate adults' and children's departments overlapped with PCT restructuring. In these circumstances, partnership building took second place and internal agendas took precedence over joint purposes which were, in any case, dominated by structural concerns rather than integrated care outcomes (Henderson et al 2011 and Windle et al 2009).

The significance of these findings is supported by our evidence about the importance for effective partnerships of appropriate relationships and behaviours no less than structures. We also noted that such relationships and behaviours based on mutual trust and confidence were influenced by continuity in personnel and structures. As we enter another period of organisational churn, established relationships are already dissolving. PCTs have shed staff and are migrating to their new clusters and integrated management teams. The already weak focus on the purpose of integration is in danger of being further diluted by national and local preoccupations with transition management in the NHS. Last November, David Nicholson (2010) referred to the associated danger that resource pressures would lead organisations to ''retreat behind their organisational or departmental boundaries and we can see that already. That will do no good for our patients, no good for our system, no good for our communities… I say to NHS leaders at the moment that leadership is not about building walls around your organisation, it's about seeing beyond them…''

Ensuring a focus on shared outcomes under the combined pressures of transition and financial scarcity is a major challenge. Already there are concerns that existing joint arrangements may be at risk, notwithstanding DH guidance that they should be retained. A number of councils and individual PCTs with joint management teams, care trusts or other partnership arrangements have written to the Secretary of State to warn that their local agreements may be at risk because of the universal requirement for existing PCTs to join clusters. The signatories cautioned that this insistence could increase costs and put service user and patient care at risk (Samuel 2011). Whatever the merits of the latter argument, the single framework for clustering seems inconsistent with David Nicholson's (2010) advocacy of a transition process in which ''people feel they're in control, so the way we organise the change needs to give people locally much more power to fashion how they take things forward''.

Devolving power

We argued that better integration was dependent on devolving power so that local actors had the space to improve outcomes by designing locally-appropriate governance arrangements and by shaping service systems in response to local needs and demands. National accountability for securing those outcomes with national policy frameworks and resource envelopes is, of course, necessary but it would not be possible to strengthen vertical and horizontal accountabilities simultaneously. Too much tension between vertical and horizontal relationships could only be resolved in favour of the former, as had been the case historically.

The NHS White Paper's emphasis on abolishing top-down micromanagement in favour of subsidiarity, outcomes and partnerships was strongly consistent with our principles of better integration. It offered the prospect of finding a new balance between vertical and horizontal influences which would support partnership working. However, it was also a fundamental challenge to traditional NHS management cultures and interests the devolution of commissioning budgets to less experienced GPs seemed to threaten Treasury controls (Health Committee). As a result, there has been both an emphasis on 'maintaining a strong grip on the system during 2011/12' (DH 2010c) and the hierarchical role of the National Commissioning Board as the new arrangements come into effect. Appearing before the Health Committee before Christmas, David Nicholson did not disagree that many PCTs were "effectively in meltdown" (though the Secretary of State did) and admitted "Stalinist" Whitehall controls would be needed (at least temporarily) to implement the changes.

His most recent letter (February 2011) on managing the transition has also begun to spell out the longer-term role of the NHSCB and the balance between its national responsibilities and the local ones of GP consortia.

The letter re-emphasised the need not to lose sight of what that system was being designed to achieve and re-stated that the central role of commissioners was to drive improvements in health outcomes. In turn, that would "require an externally-oriented commissioning system, highly engaged with and learning from partners across different sectors and industries" (Nicholson 2011). 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. The board will be confident about leading change at scale – not through top-down diktat, but neither being shy about claiming a leadership role.

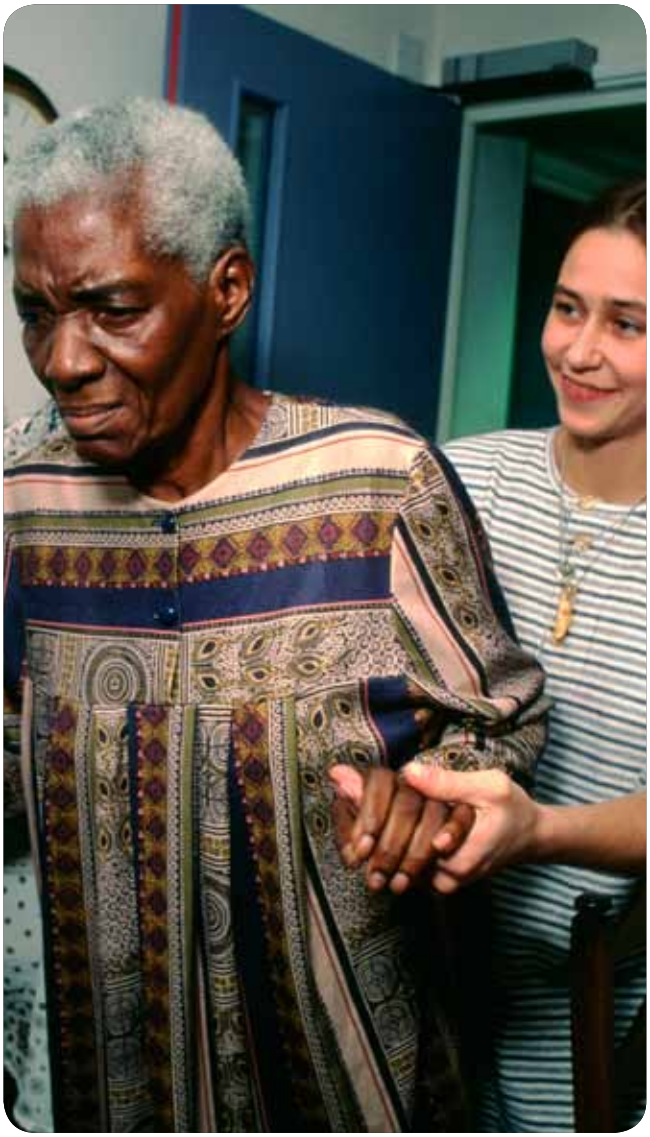
Consequently, the board would both provide ''a national framework for local commissioning'' based on the 'national mandate' agreed with the Secretary of State and Parliament, and also ''offer a spectrum of support, from empowering and facilitating success, to intervening to support consortia in difficulty''. This would mean creating ''an integrated system between consortia and the board, which supports the delivery of national accountabilities as well as local priorities''. The letter explicitly noted that, at local level, ''consortia will also need to work closely with health and wellbeing boards to ensure alignment and integration between commissioning for the NHS, public health and social care''. However, there is at least a hint that this role is secondary to the influence of the national board operating

“at the centre of a wider commissioning system focused on improving quality and outcomes for patients and making the NHS sustainable for the future”.

We are currently left then with an as-yet unresolved tension between the national coordinating role and accountabilities of the NHS Commissioning Board and the local coordinating role and accountabilities of local authorities. Correspondence between parties on the extent to which the various parties have ‘taken account’ of others’ commissioning plans, mandates and needs analyses should enhance transparency but not necessarily resolve differences. The on-going design of performance and accountability systems will be critical to the operation of the new framework.

Some of the developments highlighted above appear to suggest a concentration on internal NHS agendas and a dilution of the perceived local leadership and coordination roles of councils. There is also an inherent risk that organisations will default back to established cultures and ways of working, especially given the scale of risks and challenges implied by this change agenda. Yet quality, patient outcomes and financial sustainability in the NHS are all purposes which cannot be achieved outside of vigorous and creative partnerships with the wider local authority and community resources. Whole systems thinking and supporting behaviours have to be supported and incentivised. The local NHS must be held accountable for the outcomes it achieves with public monies but its hierarchical support and performance management systems must also be consistent with securing better outcomes through stronger integrated care and governance arrangements at local level.

Intellectually, the task remains one of designing an appropriate balance between national accountabilities and locally-integrated outcomes. Practically, it involves managing a degree of risk and subsidiarity which command and control cultures inevitably find difficult to accommodate. If horizontally integrated joint commissioning were to become a side-show to vertically-integrated NHS commissioning, there would be continuing risk of the NHS doing the wrong things well. The kind of NHS we end up with will determine the kind of integration arrangements that are possible, therefore. In turn, that will determine the kind of outcomes that can be achieved and, thus, the quality and sustainability of the NHS over time.



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