SUCCESS AND FAILURE IN JOINT PLANNING

A Report for the Social Work Services Group

David J Hunter
Health Policy Analyst

with

Sarah Price
Research Officer

King's Fund Institute
London

June 1988

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Coordination is one of the golden words of our time. Offhand, I can think of no way in which the word is used that implies disapproval. But what does it mean? Policies should be mutually supportive rather than contradictory. People should not work at cross-purposes. Participants in any activity should contribute to a common purpose at the appropriate time and in the right amount to achieve coordination.

Aaron Wildavsky (1979), The Act and Craft of Policy Analysis, London: Macmillan, 131-2.

The sense of the literature is that few coordination projects have made an important contribution to client well-being. It has proven much more difficult than was generally anticipated to change the ways in which services are delivered to clients at the local level.

Martin Rein (1983), From Policy to Practice, London: Macmillan, 74.

It is clear that progress can be made in terms of joint planning, collaboration and the provision of integrated services. It is also clear that effort required is specific, major and multi-level if success is to be achieved.

Social Services Inspectorate (1988), Joint Planning and Collaboration at the Interface of NHS/SSD, London: SSI/DHSS, paragraph 1.5, 1.

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ACKNOWLEDGEMENTS

This report was prepared while on secondment to the Social Work Services Group in the Scottish Office between mid January and the end of March 1988. I thank my colleagues in SWSG for their support and guidance in the execution of the review of joint planning. I am indebted to Sarah Price, Research Officer, King's Fund Institute who painstakingly sifted through the numerous examples of good and bad joint planning and prepared brief profiles of each. These form the basis of sections 3 and 4 of this report. Thanks also go to Sue Roberts and Su Bellingham who coped efficiently with the typing. Finally, my thanks go to Ken Judge, Director, King's Fund Institute, who agreed to 'loan' me to the Scottish Office for three months or so.

INTRODUCTION

1. Background

1.1 Promoting joint planning between the principal agencies involved in health and social services, ie. health boards and local authority social work departments, has been a key theme in central government policy across the UK since the first reorganisation of the NHS in 1974. In Scotland, support for joint planning has most recently been endorsed in the 1985 Scottish Office circular, NHS 1985 GEN(18).

1.2 Joint planning has proceeded at a different pace both across the UK and within each of the four countries making up the UK. Northern Ireland is unique in having joint boards administering both health and social services. Elsewhere in the UK, the mechanisms and legislative bases for joint planning are broadly similar although important differences remain. It is not the purpose of this report to review and compare in detail practice in different parts of the UK. In any case, that task has been substantially completed for Britain by Hunter and Wistow (1987;1988). The conclusion reached in their review of practice at national and local levels was that the evolution of joint planning has varied markedly across Britain in terms of timing, resources, and direction.

1.3 For a variety of reasons documented by Hunter and Wistow, joint planning in Scotland has tended to lag behind comparable developments in England and Wales. This is not to suggest that Scotland should

merely emulate developments elsewhere or that in some sense England and Wales have got it 'right'. Indeed, a recent report from the Committee of Public Accounts (1988) noted the DHSS's concern that joint planning remained problematic in a number of health authorities. The value of the differences which exist is to provide opportunities for policy learning and since England and Wales appear to be further ahead than Scotland in spawning new developments in joint planning there may be much to gain from a review of practice in other parts of Britain.

1.4 The primary purpose of this report is to draw on the literature on joint planning focusing on practice in England and Wales with a view to identifying potentially useful lessons which might be of value in a Scottish context. This is not to conclude that little of any consequence is happening in Scotland. Many exciting developments are underway and are being documented in a survey (Team A) which is designed to complement this report. However, in part because of the time lag in regard to joint planning noted above, it is believed that Scotland might profit from experience elsewhere. The review has been undertaken in this spirit and with this purpose in mind.

2. The Brief

2.1 In setting the remit for the review, the Social Work Services Group saw the task as comprising four elements:

- to review and analyse the relevant literature on joint planning with particular regard to the position of social work departments

- to draw out issues which highlight approaches which appear to have been particularly successful or, alternatively, to have run into difficulties

- to consider the implications for general policy in the area of joint planning

- to consider whether improvements could be effected and make appropriate recommendations.

2.2 The sections which follow the introduction attempt to meet the objectives set out in this four part remit. The Griffiths agenda for community care, which appeared in the course of this review, has purposefully not been considered pending a formal response to it from Ministers.

3. Conduct of Review

3.1 There is now a sizeable literature on joint planning. It is not the aim of this report to provide a comprehensive review of the literature since that is not its primary purpose. Rather, the exercise is designed to serve as an aid to policy-makers in illuminating aspects of unsuccessful and successful joint planning. In this sense it is rather less of an orthodox literature review and rather more of a modest exercise in policy analysis.

3.2 Given the purpose of the review, its time scale (ie completed in around four months from mid January to mid-May 1988), and the range of available material both published and 'semi-published' certain choices had to be made in order to render the task manageable and to maximise its practical utility. Four merit comment.

3.3 First, the review is not confined to a particular care group but extends across the four main so-called priority groups: elderly (including elderly mentally infirm), mentally ill, mentally handicapped, and physically handicapped people. Obviously, the literature on joint planning is uneven across these care groups in part reflecting differential progress in regard to each of them. This is particularly evident in respect of jointly planned developments for physically handicapped people where progress has been especially slow (Beardshaw, 1988).

3.4 Second, it is important to be clear about what joint planning is intended to achieve. As a number of commentators have stressed, to view it in isolation runs the risk of being over concerned with means at the expense of ends. For present purposes, joint planning is seen as being a crucial stage in the achievement of community care policies. The emphasis in the review is on the process of joint planning rather than on its specific outcomes. The review does not comment on the nature of the outcomes - it is sufficient to know that a particular scheme, or approach to joint planning, has been underpinned by a clear notion of outcome or set of objectives regardless of the precise merits or demerits of these.

3.5 Third, the review of joint planning concentrates on identifying what appears to be a common set of issues in relation to (a) the opportunities and possibilities evident in 'successful' schemes, and (b) the problems arising from attempts to operationalise joint planning. Such an approach stands accused of overlooking, or being insensitive to, differences resulting from different client groups. In the context of the review, this was not considered to be a major concern. There appears, from scanning the available literature, to be a high degree of convergence concerning the factors making for success (and failure) across all groups.

3.6 Fourth, joint planning may be said to occur at three levels: national, local and 'street' levels. Although these levels can be disaggregated and considered separately, in practice they interact. What happens at one level will, whether intended or not, have ramifications upon the others and this will apply in either a 'bottom-up' fashion or a 'top-down' one. The review concentrates on the second and third levels although each has implications for developments at national level (and vice versa). Joint planning may be said to be a feature of local level activity whereas joint working may be said to describe more accurately collaborative activity at street level. While joint planning focuses on structures and machinery designed to aid collaboration, joint working focuses on individual roles and personalities which enable different professionals to work together. It is possible to consider joint planning and joint working as distinct activities but it makes more

sense to assess them together since, as the review concludes, both are necessary for effective joint planning.

3.7 Material for the review was collected following a computer search of the available literature on joint planning undertaken by the library at the King's Fund Centre . There are basically two types of literature on joint planning: general descriptions and analyses of the process of joint planning, and documented examples of joint planning in action which range from the reasonably systematic evaluation of a specific project to the more common anecdotal account which appears frequently in the practitioner journals. The focus of the search was on literature of the second kind since the author was already familiar with material in the first category.

3.8 Given the limitations of the documented examples of successes and failures in joint planning, it is inevitable that this review reflects these shortcomings. There was no opportunity to follow up the examples in greater detail. A total of 60 initiatives was studied which broke down into the four priority groups as follows (see Appendix 1 for a complete listing; those schemes cited in the text are also mentioned in the references):

Client Group	*No. of Schemes*
Mentally Handicapped	21
Elderly	22
Mentally Ill	12
Physically Disabled	5
TOTAL	60

Note: Some of the projects embrace more than one client group

3.9 The documented examples of schemes involving joint planning were collected and analysed according to a simple set of categories (see Appendix 2). From an analysis of the material, factors were derived which either facilitated joint planning or acted as constraints upon it. Some factors were neutral in that in several examples they aided joint planning whereas in others they served to render joint planning more difficult.

3.10 The factors which were derived from the examples reviewed appear to be remarkably robust in that they were alluded to in one form or another in many of the examples unearthed as well as receiving mention in more general accounts of joint planning. Therefore, it is possible to have reasonable confidence in their salience.

4. Plan of Report

4.1 The report is in five sections. *Section 1* provides a general background context for joint planning as it has evolved in the UK since the mid-1970s. It can be skimmed or omitted by readers already familiar with developments in this area but may provide a useful background context for the uninitiated. *Section 2* sets out how theories of how organisations operate can assist in understanding the conditions under which joint planning can either succeed or fail. It argues that joint planning as a policy instrument is implicitly if not explicitly underpinned by a particular view of how organisations function which may be misleading or inappropriate and account for lack of progress. An alternative way of looking at how organisations function is advanced. *Section 3* examines the principal obstacles

encountered in joint planning. *Section 4* examines factors making for success in joint planning. *Section 5* reviews the implications for policy in the light of the material presented in *Sections 2 to 4*. While most of the recommendations are directed towards joint planning at the local and 'street' levels, it is suggested that there are also implications for central government in helping to create the conditions under which joint planning may prosper.

SECTION 1 : A SELECTED HISTORY OF JOINT PLANNING*

1.1 Arrangements for Collaboration: Scotland

1.1.1 As elsewhere in Britain, existing arrangements for inter-agency collaboration stem from the 1974 reorganisation of the NHS. A key theme of the reforms was integration and although this referred principally to closer working relationships between the three sectors comprising the NHS - primary care, community health, and hospitals - it also covered relations with local authorities which had hitherto been virtually ignored.

1.1.2 Despite a steady commitment to joint planning and collaboration displayed by the government across Britain (see below), Scotland has been accused of being less obviously committed to this endeavour, and the mechanisms and procedures introduced (and not introduced) over the last decade or so are said to reflect this difference (Martin, 1984).

1.1.3 Since 1974 the boundaries of 11 out of the 15 health boards have matched those of the regional (or island) authorities which are responsible for social work services. In Strathclyde Region, covering about half the country's population, there are four health boards and it is claimed that this has produced particular problems with regard to collaboration. The changes in the structure of the

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* This section draws heavily upon Chapters 6 and 7 of Hunter and Wistow (1987).

NHS in Scotland following the 1984 reforms occurred principally at the level below health boards and therefore did not directly affect arrangements for joint planning. The important intermediate level for the purpose of joint planning is that of health boards and regional councils and it remains unaffected by the 1984 changes. In this respect Scotland differs significantly from the position in England following the structural reforms in 1983 (see below). In particular, since 1974 there has been greater stability in the Scottish arrangements. Whether joint planning has benefited from this is hard to say.

1.1.4 The existence of coterminosity is believed to be important by many of those involved in joint planning at local level who claim that there is better cooperation where health and local authorities share common boundaries. Another factor alleged to aid collaboration, and possibly a more important one in a Scottish context, is the scale of operations. Because of its size it is claimed that in Scotland cooperation ought to be easier because the lines of communication are shorter thereby facilitating contact between the parties involved.

1.1.5 Despite these claimed advantages, there is mounting evidence that joint planning and collaboration has not taken root in Scotland or been pursued with the same apparent vigour as in either England (or in parts of it at least) or Wales. The reasons for this are considered below. First, however,the arrangements for joint planning in Scotland are reviewed in a little more detail.

1.1.6 There are two principal mechanisms for promoting collaboration between health and local authorities: joint liaison committees (JLCs) and their associated officer groups, and support finance. Mention also needs to be made of health boards' own sporadic and uneven attempts at planning which have a 'joint dimension' since they include input from agencies other than health. There exists no formal local planning machinery akin to health care planning teams or joint care planning teams in England but programme planning committees (PPCs) were set up by most health boards for a time following the 1974 reorganisation. Several boards have recently revived these committees, or have established similar groups, partly in response to criticism that the reports produced in the late 1970s did not appear to have been implemented, and partly in response to the requirements set out in the most recent circular on joint planning (Scottish Office, 1985) that health boards and local authorities should produce 10 year joint plans. Virtually all joint planning machinery has been health service led although social work departments may have been influential in getting it established initially. Planning generally has a higher profile in health boards than in SWDs a view which is widely shared by commentators on joint planning in other parts of Britain.

Joint Planning

1.1.7 In 1977 a working party on relationships between health boards and local authorities (SHHD, 1977) reported and its recommendations have guided all subsequent developments in this area in Scotland (see Table 1 for a chronological listing of key developments). Its main

TABLE 1

JOINT PLANNING AND SUPPORT FINANCE IN SCOTLAND: MAIN DEVELOPMENTS 1973 - 1987

1973	Scottish Home and Health Department (SHHD) Circular HSR(73)C26 Cooperation and Liaison with Local Authorities during the next two years. Early guidance issued to health authorities in respect of liaison arrangements with local authorities. Produced by Working Party on Relationships Between Health Boards and Local Authorities.
1974	Reorganisation of Scottish Health Service on 1 April. Emphasis on fostering close working relationships with local authorities but precise machinery not specified in legislation.
1976	SHHD publishes a 23 page memorandum on health service priorities, The Health Service in Scotland - The Way Ahead. It contains a brief mention in the final paragraph on the need for 'close and continuing consultation with local authorities'.
1977	Report of Working Party on Relationships Between Health Boards and Local Authorities (Chairman: J A M Mitchell). The Working Party was set up in 1975 to consider matters relating to cooperation between health boards and local authorities.
1980	Support Finance is introduced by the joint SHHD NHS Circular No 1980 (GEN)5 and Social Work Circular No 2/1980 of 14 March.
	SHHD publishes its major national policy priorities statement, Scottish Health Authorities Priorities for the Eighties (SHAPE), which develops the priorities set out in The Way Ahead. SHAPE states: 'collaboration in planning and in the sharing of resources between health boards and local authority services is crucial to the success or failure of attempts to achieve the proposed objectives. Failing close collaboration at every level, results will continue to fall far short of what is attainable...' (paragraph VII.I, 74).
1981	SHHD, Monitoring of Progress Towards Implementing the SHAPE Priorities, NHS Circular No 1981(GEN)46. Sets out procedures to be followed by health boards including submission by boards to SHHD of priorities statements and analyses of expenditure by programme for each financial year.
1985	Scottish Office, Community Care: Joint Planning and Support Finance, NHS Circular No 1985(GEN)18, Social Work 5/1985. Emphasises importance of joint planning and announces changes in support finance arrangements.
	Scottish Health Service Planning Council's Interdepartmental Working Group to review SHAPE, set up in November 1984, starts work in July with a programme of monthly meetings to examine SHAPE programmes.
1986	End of March is deadline for production of joint plans by health boards and local authorities. Only four boards had submitted plans to SHHD by the end of 1986. The first to do so was Lothian. The remaining boards and authorities are at various stages in the production of plans.

National Health Service (Amendment Act). This includes a clause giving reserve powers to the Secretary of State for Scotland to require joint planning where he feels progress is not being made on a voluntary basis. The clause had its origins in the Private Members' Disabled Persons Bill which received the Royal Assent in July 1986 but was inappropriate in this Bill and had to be re-introduced in the NHS (Amendment) Bill. There is no intention to use this power unless the present non-statutory arrangements have clearly failed. What might constitute failure is not specified. A circular on the reserve powers and the Scottish Office's commitment to joint planning is promised.

1987 Review of SHAPE completed. Planning Council's report, Scottish Health Authorities Review of Priorities for the Eighties and Nineties (SHARPEN), put out on limited circulation for comment.

1988 SHARPEN endorsed by Planning Council. Response from Ministers awaited.

recommendation was for the establishment of JLCs which would advise on the planning and operation of services of common concern. While JLCs represented the formal machinery the report also recommended close working arrangements between officers of health boards and local authorities. These would be more informal and would be concerned with ensuring proper coordination in day to day operations and in forward planning. The working party thought that there should be only one JLC in each region to deal with services at both regional and district levels. Arrangements in Strathclyde would be different since, as mentioned already, the region covers an area of four health boards.

1.1.8 The working party did not recommend that JLCs should be empowered to commit the constituent authorities since this would amount to an unacceptable erosion of responsibility from these authorities. JLCs were to be member and officer bodies and should meet at least three times a year. Working groups of officers were to be established to advise JLCs on particular issues of joint concern like care of the elderly, the mentally handicapped and so on.

1.1.9 Unlike their English counterparts, JLCs are not statutory bodies and not all health boards possess them although the majority does. Whether or not joint planning is any less effective in those boards because they do not have a JLC is an issue for consideration. The evidence from England and Wales, reviewed in later sections, suggests that the reality is rather more complex even where collaborative machinery is statutory. The only statutory requirement on Scottish

health boards is that they undertake to collaborate but the mechanism by which they do this has no statutory basis.

1.1.10 The 1977 working party's recommendations were eventually adopted in a circular (SHHD, 1980a), published four years after the English equivalent, which gave an undertaking that the arrangements would be reviewed in the light of experience. Such a review was undertaken five years later in April 1985 when the 1980 circular was replaced by new guidance (Scottish Office, 1985) which followed nearly a year of consultation.

1.1.11 The 1985 circular reaffirmed the Secretary of State's objective of promoting closer collaboration between not only health boards and local authorities but also voluntary agencies and other organisations. The circular re-emphasised that boards and authorities have a statutory responsibility to cooperate with one another and that the framework for this in most areas exists in JLCs. But the circular also conceded that in practice cooperation between these bodies and the JLC arrangements 'have not been uniformly successful' (paragraph 4:2). In order to improve existing arrangements the Secretary of State asked that joint plans be prepared for services for the priority categories in SHAPE (SHHD, 1980b). In the first instance the 10 year plans would 'be for the guidance of the health board and the local authorities concerned; they need not be formally submitted to the Secretary of State, and will not require his approval, although it would be helpful if copies were sent to him' (paragraph 6:2). The first round of plans were to

be drawn up not later than the end of March 1986 and were to be kept under continuing review thereafter. Only a handful of health boards met the deadline for the preparation of joint plans. The remaining 12 health boards have been completing their respective joint plans since then. At the time of writing a number of health boards had yet to produce joint plans.

1.1.12 The response to the 1985 circular was rather mixed. For those pressure groups who were anxious to see joint planning put on the same statutory basis as England and Wales, the circular came as a disappointment. It led to pressure to include a clause requiring the Secretary of State to put JLCs on a statutory footing being inserted in the Tom Clarke Bill to improve service provision for disabled persons. This bill later became the Disabled Persons (Services, Consultation and Representation) Act 1986.

1.1.13 Technical difficulties prevented the introduction of a clause to cover the full range of priority groups for which existing joint planning arrangements in Scotland provide. The government therefore introduced an amendment to the NHS (Amendment) Bill which, on becoming an Act in 1986, put into statute a provision identical to that envisaged for the Disabled Persons Act. The new clause on joint planning in Scotland requires the Scottish Office to put joint planning machinery on a statutory basis if the present voluntary arrangement fails.

1.1.14 It is for the Secretary of State to decide if the voluntary arrangement has failed and whether, therefore, to invoke his reserve powers. A circular setting out the new reserve powers, and possibly making explicit the criteria governing their use, was promised by the former Health Minister, Lord Glenarthur, when he addressed a conference on joint planning in Edinburgh at the end of January 1987. At the time of writing a circular had yet to appear.

The Record of Joint Planning

1.1.15 In contrast to developments in England and Wales (of which more later), the record of joint planning in Scotland has been remarkable for the virtual absence of significant progress. Joint planning does not appear to be regarded as an integral part of health care, or social care, planning. There are many reasons why this is the case. Some of them have been documented by Hunter and Wistow (1987). Following a review of joint planning in Britain, they suggested that the lack of progress in Scotland may be a reflection of the systemic hospital bias which exists within the health service. They also suggested that the lack of progress may have to do with varying conceptions of planning. While health boards possess capital planning skills, service planning skills remain weak and underdeveloped. The key factors constraining progress concern both the commitment on behalf of the two main sets of agencies to collaborate - health boards and local authorities - and the capability to operationalise that commitment where it does exist. There are weaknesses in both areas. As mentioned, the service (as distinct from capital) planning capability of health boards is

generally weak and in regard to joint planning virtually nonexistent. The problems in local authorities are possibly greater since, as mentioned already, planning skills are in even shorter supply than in the NHS. When it comes to social services planning few individuals are apparently capable of executing such a task.

1.1.16 The PPCs which operated in most boards between 1975 and 1979 gave an impetus both to service planning and to collaborative ventures with social work and housing being represented on the committees. In general, however, PPCs had no influence on policy at the end of the day (Boddy, 1979). Their benefits were indirect, such as fostering cross-sector links. They also gave the priority care groups a certain status within health boards, both raising their profile and partially compensating for their traditional neglect. The PPCs were advisory and had no direct access to the health boards, although board members were included in the membership. In the end, PPCs withered away. Once they had reported there was no further role for them since they had no remit to monitor the implementation of their plans. In most health boards, the committees were not formally abolished but simply went into recess.

1.1.17 For the past six to seven years, there has been little or no joint planning activity in Scotland apart from JLCs which meet, in the main, once or twice a year with officer support groups meeting more often. In the past year or so, as noted earlier, there has been a revival of interest in PPCs or some variant of the model underpinning them.

1.1.18 Available evidence, both anecdotal and from a variety of research studies and surveys (Hunter, 1980; Gray and Hunter, 1983; Brown, 1985; Care in the Community Scottish Working Group, 1986a and 1986b; University of Aberdeen/Loughborough University, 1986; Scottish Action on Dementia, 1986), shows unequivocally that joint planning has produced few tangible results and that JLCs do not appear to be an effective focus for joint planning. The Care in the Community Scottish Working Group has concluded that in many parts of the country the 1985 Scottish Office circular has had little impact and in some none whatsoever. In regard to JLCs, the Aberdeen/Loughborough survey found that a higher value was placed on regular officer contact than on the JLC, and the infrequent meetings of JLCs seemed to confirm this view of their worth. In the survey responses there were few comments on the circular's guidance on joint planning. Concern was confined to the revised arrangements for support finance (see below).

1.1.19 At a seminar of JLC secretaries in Glasgow in December 1985 organised by the Care in the Community Scottish Working Group (1986b) the conclusion reached was that despite a spate of activity as health boards and local authorities reassessed their joint planning machinery and set up new groups, the new arrangements had yet to bear fruit. Moreover, there were major issues still to be tackled in Scotland such as establishing a clear and unequivocal commitment to community care at national level in order to provide a supportive environment in which to proceed.

Support Finance

1.1.20 Support finance did not get underway in Scotland until 1980, four years or so after the introduction of its counterpart - joint finance - in England (see Table 2). According to the then Secretary of the Scottish Home and Health Department, in evidence to the Public Accounts Committee in January 1983, the reason for the delay was that health boards had expressed reservations about support finance and it took some time before a consensus view emerged which enabled a viable scheme to be launched (Committee of Public Accounts, 1983). Certainly a number of areas in Scotland did not approve of support finance and refused to touch it. In particular, several local authorities, including the largest region in Scotland, Strathclyde, were firmly opposed to it on political grounds. Their view was that support finance would, in effect, preempt and distort the priorities of the regions in years to come. Consequently, between 1980 and 1985, when the method of allocation was revised (see below), take-up across the country varied markedly. This worked to the advantage of some health boards, notably Highland, which where able to lay their hands on quite sizeable sums of money.

1.1.21 The objectives of support finance are virtually the same as those applying to England. Support finance was viewed as a mechanism which might help ensure that the priority groups identified in SHAPE received the most appropriate form of care with the emphasis on non-institutional provision in the community. The scheme should not normally provide for grants of more than 60 per cent (this was

Table 2 Comparison between arrangements for joint finance (England and Wales) and support finance (Scotland)

	1 *England*	2 *England*	3 *Scotland*	4 *Scotland*	5 *Wales*	6 *Wales*
Introduction	1976	Major revision 1983	1980	Revised 1985	1977	Revised 1983
Scope	PSS, voluntary organisations (from 1977), primary and community health (from 1977)	From 1.4.84 – PSS, housing, education, voluntary organisations, primary and community health	Social work, voluntary organisations	From 1.4.85 – social work, voluntary organisations, housing, education	PSS, voluntary organisations	As England (column 2)
Capital payments	60% contribution 'might be a reasonable figure' but higher contributions (up to and including 100%) may be made.	No hard and fast rule; in normal circumstances should not exceed 2/3 of the total cost, but higher contributions up to and including 100% may be made.	Generally not more than 60% of total cost, although 'there may be occasions where a higher contribution might be appropriate'.	As England (column 2)	As England (column 1)	As England (column 2) except normally 50% of final cost.
Revenue payments						
Time limit	Initially not more than 5 years; may be extended by 1–2 years.	*Joint finance schemes*: up to and including 100% for up to 3 years, tapering off over more than a further 4 years; may be extended by a further 1 or 2 years with Secretary of State approval.	Initially, not more than 5 years; may be extended by 1–2 years.	As England (column 2) except that SHHD should be informed of all instances where there has been an extension.	As England (column 1)	As England (column 2) but flexibility can be shown if justified.
Limit of contribution	No hard and fast rule; contributions may be up to 100%. But if the initial contribution is more than 60% norm, tapering may be sharper.	*Care in the Community* (schemes for people moving from hospital to community care) a. Payments from joint finance monies: up to and including 100% for 3 years, tapering off over no more than a further 4 years. In special circumstances, 100% for 10 years, and payments of less than 100% for a further 3 years. b. Payments from health authorities' normal allocations: up to 100% indefinitely (subject in due course to a central transfer of resources).	Generally not more than 60% of project cost in the first year; must taper off (the tapering pattern is not prescribed but is usually a 10% a year reduction).	a. 100% of project cost for up to 3 years. Thereafter tapering off (pattern not prescribed) over no more than a further 4 years. b. Lump sum or continuing payments by health board to local authorities to facilitate transfers from hospital to community (arrangements not prescribed) – may be subject in due course to permanent transfer of resources.	As a general rule initial contribution 60%. In some cases a higher level of support is possible but with sharper tapering.	As England (column 2) for (a) and (b) except Welsh Office contributes 50% of health service contribution; health authorities match this from their own main allocations; earmarking of NHS funds in Welsh Office in respect of the development of community based services for mentally handicapped people over a period of ten years.
Allocation made by	DHSS makes allocation to RHAs on a *per capita* basis, weighted to take account of the numbers of mentally ill, mentally handicapped and the over 75s. RHAs allocate to DHAs normally under similar formula.	Same as column 1	SHHD, which evaluates bids from health boards for allocations in respect of specific projects.	SHHD makes allocation to health boards distributed under SHARE formula. Department indicates a minimum sum which it expects each board to devote to projects. The indicative allocation to be based on population of area, weighted to account for those in need of long term care.	As Scotland (column 3) but Welsh Office provides 50% of health service contribution; health authorities match this from their own main allocations.	Same as column 5
Joint planning arrangements	All projects must be approved by the appropriate joint consultative committee.	Same as column 1	No formal role for (non-statutory) joint liaison committees (JLCs).	Same as column 3, although joint plans to be prepared by JLCs.	Same as column 1	Same as column 1

Source: D.J. Hunter and G. Wistow (1987) Community Care in Britain: Variations on a Theme London: King Edward's Hospital Fund for London

changed to 100 per cent in 1985). Support finance was seen as experimental and limited in scope and performed a pump-priming role. The intention was that if an idea worked it would then be taken into mainstream funding.

1.1.22 The discrepancy between the amounts of money available in Scotland and England (see Table 3) is officially explained as being partly due to the fact that the Scottish arrangements were not introduced until four years after those in England and the Scottish scheme had not accumulated a correspondingly large number of continuing projects. Although the initial per capita level of support finance in Scotland was similar to the corresponding figure when the English scheme was introduced in 1976, it has not increased as rapidly over the years as the respective figures in Table 3 show. There were a number of reasons for this. First, Scotland started where England started instead of starting where England had got to in four years. Second, there was a difficulty in justifying large increases in the overall amount available when in the first four years the rate of take-up was slow. Third, there was resistance to top-slicing too generously since the greater the amounts taken off the top of the general health service budget for support finance, the smaller the amounts available to health boards for general revenue distribution thus reducing, on a geographically arbitrary basis, the scope for local decisions on resource allocation. Unlike England, therefore, Scotland did not opt for large annual increases in the early years.

TABLE 3 AMOUNTS AVAILABLE FOR ALLOCATION FROM CENTRAL FUNDS 1980/81 TO 1985/86

Gross £m	*1980/81*	*1981/82*	*1982/83*	*1983/84*	*1984/85*	*1985/86*
Scotland	1.0	1.1	2.0	3.2*	4.6	6.0
England	61.0	75.3	84.7	94.1*	99.5	105.0
Wales	0.5	0.6	1.1	1.2	1.6	1.4
Per capita £						
Scotland	0.19	0.21	0.39	0.63	0.89	1.15
England	1.31	1.62	1.18	2.01	2.11	2.23
Wales	0.18	0.21	0.39	0.43	0.57	0.50

* Reduced from £96m respectively following the Chancellor's announcement on 9 July 1983.

Source: Department of Health and Social Security, Scottish Home and Health Department and Welsh Office.

1.1.23 Support finance, then, started life under far tighter central control over its management and distribution than existed in England. In this respect it resembled the mechanism in Wales (see below). From 1980 until 1985 funds top-sliced from the NHS vote were retained by the SHHD and the 15 health boards were invited to submit bids.

1.1.24 The arrangements for support finance were revised in 1984 and a circular announcing the changes appeared in 1985 (Scottish Office, 1985). The changes were founded on the assumption that more effective local collaboration would best be encouraged by the removal, as far as possible, of intervention from the centre in the joint deliberations of health boards and local authorities. Local authority and voluntary interests complained that the terms on which support finance was made available were insufficiently attractive particularly by comparison with the more generous terms introduced in 1983 by the DHSS and the Welsh Office. The circular stated that the Scottish Office should disengage itself completely from day-to-day involvement in the operation of support finance but that the SHHD should give each health board a mandatory indication of the sum which it expected it to devote to support finance projects from within the normal revenue allocations. The indicative allocation, based on the population of the area, weighted to account for those in need of long term care, represented a minimum sum for each health board. Boards could exceed this indicative allocation if they wished. The SHHD has said that it will know of the use made of these resources both as a result of monitoring the progress made towards implementing the SHAPE

recommendations and through receiving copies of memoranda recording agreements made between health boards and local authorities.

1.1.25 In addition to disengagement by the centre the other major change was a widening of the scope of support finance to include appropriate housing and education initiatives thereby bringing practice into line with that in England. Also, the flexibility of support finance was increased so that health boards might meet up to 100 per cent of the revenue costs of projects for up to three years. Tapering would begin after this period although the precise pattern was for local decision. The normal limits of payments through support finance was seven years. In exceptional cases, not specified in the circular, support finance might be extended for a maximum of 13 years.

1.1.26 While in many respects arrangements in Scotland for the use of support finance closely resemble those in England for joint finance there are important exceptions. Whereas the DHSS allows health authorities to use centrally earmarked joint finance up to a maximum of 13 years (10 years at 100 per cent) to meet the transitional costs incurred in transfering patients from hospital to community care, this facility is not available in Scotland. In addition, the DHSS has put additional sums into the joint finance pool to promote care in the community initiatives. The Scottish Office does not offer a similar facility.

1.2 Arrangements for Collaboration: England

1.2.1 As elsewhere in Britain, the need to promote inter-service cooperation was a central theme in the build-up to the 1974 reorganisation of the NHS. Its most obvious expression was the principle of one-to-one coterminosity: the drawing of common boundaries for area health authorities and those local authorities responsible for personal social services. The value of one-to-one coterminosity has remained a controversial matter.

1.2.2 A study for the Royal Commission on the NHS (1979, paragraph 7.4:50) found that 'a surprisingly large number of respondents expressed the view that the principle of coterminosity was irrelevant or worse'. Some respondents felt it had led to the creation of health authority boundaries inappropriate to the operation of the NHS since the catchment areas of local authority and health services were not the same. However, a closer review of the evidence produced the intriguing result that support for coterminosity was strongest among those working in community services and that those furthest away from such services supported it least.

1.2.3 Certainly the proposal to abolish coterminosity as the basic building block of the NHS structure under the Patients First proposals (DHSS and Welsh Office, 1979) attracted considerable criticism from local authority interests and also those working at area level in the health service. By early 1982, a national survey suggested that opinion within the NHS was coalescing around the view that coterminosity had been valuable in getting collaboration underway but

that its loss would not, on the whole, be a permanent set back: 73 per cent of respondents indicated that coterminosity had been 'an essential precondition for the growth of collaboration' in their area, but only 36 per cent considered its loss would 'undermine attempts to develop collaboration for the foreseeable future' (Wistow and Fuller, 1983:29).

1.2.4 Boundary coterminosity was backed up by two further statutory requirements. First, health and local authorities were placed under a legal obligation to cooperate with each other in order to secure and advance the health and welfare of the population. Second, they were required to establish joint consultative committees (JCCs) to advise them on the performance of such duties and also on the planning and operation of services of common concern. While these joint committees were to be advisory rather than executive bodies, the DHSS hoped that the importance of effective collaboration would be reflected in the appointment to them of senior members from each authority (DHSS, 1974).

Joint Planning

1.2.5 The emphasis on building structures to facilitate inter-authority cooperation was rapidly followed by detailed guidance on joint planning. Health and local authorities were urged by the DHSS to develop genuinely integrated planning processes in which 'each authority contributes to all stages of the other's planning from the first step in developing common policies and strategies to the production of operational plans to carry them out' (DHSS, 1976). The

primary mechanisms for carrying out this process were multidisciplinary planning teams: a joint care planning team (JCPT) of senior officers drawn from each matching health and local authority supported, where appropriate, by sub teams with responsibility for particular client groups or issues of mutual interest, eg social work support to the health service. The joint planning initiative was intimately bound up with the establishment of an NHS planning system, also introduced in 1976, and with which it shared a number of common objectives. These included, most fundamentally, the provision of a means for adjusting the balance of resources within the NHS and between it and other agencies. The guidance stressed that 'effective joint planning is vital to the government's overall strategy for developing community-based services to the fullest extent practicable so that people are kept out of hospitals and other institutions and supported within the community' (DHSS, 1976).

1.2.6 From 1982, one-to-one coterminosity - the basic building block of the enabling structures introduced eight years previously - no longer existed in most (54 per cent) localities. One-to-one coterminosity was replaced by 'whole number coterminosity' under which the boundaries of more than one health authority were wholly contained within those of a single local social services authority. Despite the loss of one-to-one coterminosity, by 1982 the DHSS was placing renewed emphasis on the need for joint planning to implement its care in the community strategy (DHSS, 1981; 1983).

1.2.7 Up to the restructuring of the NHS in 1982, local joint planning was marked by two features: the establishment of substantial amounts of formal planning machinery, and widespread agreement that such machinery had failed to deliver the goods. Genuine joint planning of the kind outlined by the DHSS in 1976 was scarcely even a gleam in the eyes of local planners. Several commentators maintained that unrealistic and over-optimistic assumptions about the possibility of developing comprehensive rational planning processes across agency boundaries were at the root of the problem. Consequently achievements were modest (Webb and Wistow, 1985; Booth, 1981; Glennerster and others, 1983; Wistow and Fuller, 1983; 1986).

1.2.8 JCCs tended to be talking shops and JCPTs were preoccupied with joint finance and other issues which fell well short of strategic client group planning. Generally speaking, although by no means universally, inter-authority communications improved and personal relationships were cordial. However, improved relationships cannot be equated with effective joint planning. For the most part, local experiences at best amounted to a form of 'parallel planning' based on consultation and information exchange (Wistow, 1988; Challis and others,1988).

1.2.9 An analysis of joint planning in seven contrasting localities over the three years from 1979 to 1982 provided important data on the achievements of joint planning (Challis and others, 1988). Distinguishing between three categories of output the study found only two examples of joint plans for elderly people and children

under five but 40 joint projects and 24 'professional practices'. Most of these projects were, however, joint in name only being social services schemes processed through the joint planning machinery purely for the purposes of securing joint finance. In contrast, the professional practices (such as multidisciplinary assessment procedures) were more genuinely joint in origin. They also more frequently originated from practitioners and operational managers rather than planning staff working through the formal planning machinery. In short, they were examples of joint working as distinct from joint planning. As Norton and Rogers (1981, 136-137) also concluded, a bottom-up entrepreneurial approach to collaborative planning can often appear to pay bigger dividends than some formal planning procedures. But the study by Challis and others emphasised the limits of this approach in achieving change on a client group or locality wide basis. Even entrepreneurial activity required a formal structure of sorts if it was to be capitalised upon. Later sections return to these matters.

1.2.10 The majority of authorities were conscientious in following DHSS guidance to establish planning machinery, as national surveys have demonstrated (Wistow and Fuller, 1983; 1986). Almost all authorities had JCPTs in 1982 whereas only two thirds had an equivalent team of chief or senior officers in 1976. The number of officer subgroups more than doubled over the same period and, more importantly, a significant shift took place in their subject matter: in 1982 most were concerned with services for the DHSS priority groups whereas, six years previously, there had been scarcely any

joint planning machinery for these client groups. Considerable gaps remained, however: for example, less than half the localities had sub groups for mental illness or physical handicap (Wistow and Fuller, 1983). Thus, if less was achieved than the DHSS had initially hoped, health and local authorities nonetheless gave considerably greater attention to joint planning in the period after 1974. On an optimistic assessment, at least some of the basic preconditions for local joint planning were being established in England between 1976 and 1982 though the claim by Glennerster and others (1983) that the DHSS had merely made it more difficult not to attempt to plan for the priority groups was clearly justified in some localities at least.

1.2.11 A survey conducted in 1984 suggested that the pattern of joint planning machinery two years after restructuring of the NHS was broadly similar to that reported two years previously. There had been some delays in re-establishing formal collaboration machinery but restructuring appeared to have created only a hiatus in joint planning (Wistow and Fuller, 1986). However, it has to be borne in mind that these findings merely relate to issues arising from the formal machinery. The cumulative experience of research in this field is that enabling structures are only one among many factors which influence local joint planning. No less important influences include differences in financial resources, service stocks, professional viewpoints and personalities (Wistow and Fuller, 1986). Some of these concerns are examined in more detail in later sections of this report.

1.2.12 In 1984 a joint working party was established by the DHSS together with the health and local authority associations to review arrangements for joint planning and joint finance. As its report, Progress in Partnership, noted 'behind the proposal (to establish the review) was a widespread sense of frustration that more had not been achieved through joint planning' (Working Group on Joint Planning, 1985, paragraph 1.2:1). The report stressed the importance of identifying specific tasks, placing responsibility for fulfilling them on named individuals, and strengthening lines of accountability. Recognising that in the past too much had depended on 'the enthusiasm of individuals', the report saw strengthened JCCs as an 'engine to drive joint planning': senior councillors and health authority members were to join JCCs and play an active part in motivating officers; the focus of joint planning was to be 'total resource planning' rather than changes at the margin; annual reports on the work of JCCs should be submitted to the Secretary of State; and their meetings were to be open to the public. The key step to making a reality of collaborative planning was seen as 'the establishment of small, genuinely joint planning teams for each group where services need developing, with balanced representation and close links with professional, voluntary and client interests, and the abandonment of single agency planning for the client groups' (p.ii). Furthermore, NHS general managers and local authority chief executives were recommended to 'ensure that there are nominated officers accountable for joint planning activities' (ibid).

1.2.13 Perhaps predictably, there were some local government reservations about the dangers of apparently becoming tied into review and accountability processes originating in, and more properly belonging to, the NHS (Murray, 1986; Smart, 1986). In general, however, the report was welcomed by the health and local authority associations and accepted by Ministers. A draft circular based on its recommendations was put out for consultation by the DHSS in 1986. However further developments were postponed pending the outcome of the Griffiths review of community care announced at the close of 1986.

Joint Finance

1.2.14 The DHSS took an early lead in introducing joint finance in 1976. Equivalent developments did not take place in Wales until the following year and, as noted above, until 1980 in Scotland. In England, the initiative reflected a keen ministerial commitment to promote collaboration and to reduce the scale of long stay hospital provision (Castle, 1975). Since 1976, the fundamental features of the joint finance arrangements have remained basically unchanged. The history of joint finance has been marked by certain relaxations in the conditions under which it might be spent. They have been essentially concerned with extending both the range of agencies whose services might be supported from the joint finance allocation and also the period for which that support might be paid. These modifications in part reflected an acceptance that joint finance might appropriately pump-prime the full range of services involved in providing community care.

1.2.15 As a source of short term funding, joint finance is dependent on the availability of growth in mainstream budgets if it is to be of lasting benefit. Apparently as a result of the reluctance of local authorities to overcommit themselves at a time when social services growth rates were being revised downwards to two per cent per annum following a brief period of double digit growth (Webb and Wistow, 1982), the proportion of joint finance taken up in the first two years (1976/77 and 1977/78) was only 52 per cent and 75 per cent respectively (Wistow, 1983). The result was the introduction of terms designed to make joint finance more attractive to social services departments and local authority treasurers: 100 per cent rather than 60 per cent became the norm for initial levels of support with tapering thereafter taking place over a seven rather than a five year period (DHSS, 1977).

1.2.16 Evaluations of joint finance have tended to revolve around three related issues: whether it has been spent at all; whether it has been spent productively and cost-effectively; and whether it has promoted collaborative planning. In the first instance the balance of concern, both centrally and locally, was to ensure that the allocation was fully taken up. After the relatively low take-up rates of the early years, expenditure built up rapidly and health authorities are now planning to spend sums equivalent to almost all the national joint finance allocation although there are considerable regional variations. For 1985 the cumulative national take-up rate for the allocation since its introduction in 1976 stood at 98 per cent (Social Services Committee, 1985, 42-44).

1.2.17 Whether such sums have been 'well spent' is more problematic and is not unrelated to the initial low take-up rates. In the early years, at least, most joint finance projects emerged from social services rather than from joint planning processes and were readily accepted by health authorities anxious to restrict the amounts of unspent monies to be carried forward at the year end (Wistow and Head, 1981; Wistow, 1983). Since such unspent sums were included within the one per cent of their revenue allocation they were allowed to carry forward, health authorities effectively had an incentive not to impose too rigorous a review of the contribution to health service objectives which social services schemes represented. To do otherwise threatened the flexibility which the one per cent carry forward facility offered them in planning their main allocation.

1.2.18 Such considerations, together with the technical difficulties of establishing that joint finance schemes represented no less value to the NHS than if such sums were spent on health services, tended to mean that joint finance largely supported the kinds of services that social services departments' might have developed in any case. Significantly, a national survey of health authorities conducted in 1982 found only 14 per cent reporting that joint finance had enabled them to influence social services departments' priorities (Wistow and Fuller, 1983: 25). The impact of resource scarcity on local authorities was also seen to be influential: 44 per cent of respondents in the same survey recorded that joint finance had been used predominantly to cushion from the effects of expenditure

constraints developments planned separately by social services departments.

1.2.19 Joint finance did not contribute directly to the more rapid run down of long stay hospitals by enabling existing patients to be transferred to local authority care and the resulting spare NHS capacity taken out of commission. At best, joint finance contributed towards maintaining people in the community and was of indirect benefit to the NHS by delaying or preventing hospital admissions. Joint finance was seen as too limited in its scale and period of support for it to make possible a direct and permanent switch in responsibilities for patients with no further need of a hospital bed. Such considerations came together in the 'Care in the Community' arrangements (DHSS, 1983). This initiative resulted in a refocussing of financial incentives in joint planning on the closure of long stay hospitals. A fundamental concern, however, is evidence suggesting that health authorities might seek to develop community care models within the NHS rather than agree transfers to local authorities (Wistow and Hardy, 1986). Such evidence is reinforced by the trends shown in financial returns made to the DHSS by health authorities to spend increasing proportions of their joint finance allocation on health services (Working Group on Joint Planning, 1985). Indeed, NHS spending of joint finance appears to have doubled in the period since 1981/82, having reached almost 20 per cent of all joint finance expenditure by 1984/85 (Wistow and Fuller, 1986: 44). There are signs, therefore, that social services dominance over joint finance allocation processes in the early years may now have been replaced by

an emerging NHS dominance. The extent to which the device of joint finance may have led to a distortion of joint planning rather than facilitating it is considered in a later section.

1.3 Arrangements for Collaboration: Wales

1.3.1 From 1974-1982 the basic structural arrangements for promoting health and local authority collaboration in Wales paralleled those in England. The same legislation imposed identical statutory duties for health and local authorities to collaborate and set up JCCs. However, the Welsh Office adopted a less prescriptive approach than the DHSS to the creation of planning machinery to support JCCs. Whereas authorities in England were required in 1976 to establish JCPTs of senior officers, the equivalent Welsh Office circular merely invited authorities 'to consider the possible advantages' of, inter alia, 'setting up a supporting planning group of officers' in areas where such a mechanism did not exist (Welsh Office, 1977, paragraph 5).

1.3.2 Further differences between England and Wales began to emerge with the 1982 restructuring of the NHS. The fundamental distinction between them lay in the retention in Wales of health authorities coterminous with local social services authorities. The emphasis in Wales was on minimising disruption to health and local authority collaboration through the retention of coterminosity. It is not clear that the absence of disruption to the structures associated with health and local authority joint planning has enabled cooperative working to advance any more smoothly than - or even to the same extent as - in England.

Joint Planning

1.3.3 Evidence about collaboration in Wales is scanty. Although the national surveys of 1982 and 1984 included Wales, the level of returns was too small for meaningful analysis. Given the relatively high response rate in England for each of the surveys (79 per cent and 74 per cent respectively), this experience may itself suggest a lower degree of interest in collaboration within the Principality.

1.3.4 The advent of the All-Wales Strategy for Mentally Handicapped People is seen to be making some impact on the need to strengthen planning relationships between health and local authorities. The Strategy has provided the Welsh Office with leverage to secure joint planning at local level. For the first time, health and local authorities are being required to submit a joint plan for a specific client group and resources can be withheld by the centre if the plan does not show evidence of genuine joint planning. While the influence of the Strategy and of its mechanisms for ensuring collaboration are generally acknowledged, opinion in Wales is divided as to its effect on joint planning across the board. There is an argument that the Strategy has diverted attention from effective joint planning in regard to other care groups such as the elderly and the mentally ill. It is alleged that joint planning for these groups is not being accorded the same degree of attention as that for mentally handicapped people. However, a strategy for mentally ill people has recently been announced by the Welsh Office.

1.3.5 An efficiency scrutiny of community care carried out between January and August 1987 concluded that for mental handicap services the existing All-Wales Strategy needed strengthening and/or modifying in several ways. In particular, 'the Strategy must get to grips with measuring need and it should apply its planning to the total resources available, not just the incremental element' (Kilner, 1987). The scrutiny concluded that the general approach adopted by the Strategy 'seems likely to succeed and ...should be maintained'.

1.3.6 Evidence from visits by the Health Advisory Service (HAS) to Welsh authorities presents a picture of limited progress in joint planning for the elderly and the mentally ill. Little, if any, evidence emerges of effective joint planning for these groups and in some cases relationships appear to be negative rather than merely underdeveloped or lacking in commitment. Indeed, considerable scepticism about the value of joint planning was voiced by the HAS and concern was expressed that joint planning appeared to be thought of as something only concerned with the best way of using a marginal amount of additional resources.

Joint Finance

1.3.7 In keeping with thinking in England and Scotland, joint finance in Wales was seen as desirable to 'encourage and facilitate joint planning' (Welsh Office, 1977, paragraph 13:4) and 'to ease the constraints which arise from the necessary dividing line between two separately accountable services' (paragraph 9:3). However, the circular emphasised that 'the major task is to make a reality of

joint planning, most of which will not involve the use of joint finance' (paragraph 13:4). Joint finance, as mentioned, was introduced a year later than in England following a long argument within Wales as to whether it should be introduced at all. There was greater scepticism over the alleged benefits of joint finance for joint planning and, consequently, a different emphasis from that evident in England. Whereas the DHSS defined the principal purpose of joint finance as being to promote joint planning, in Wales it was seen as a mechanism to develop services.

1.3.8 There are differences between England and Wales in the use of joint finance. Whilst in respect of 'Care in the Community' projects more flexibility was possible in Wales, in most other cases the local authority is expected to contribute 40 per cent of the total and the Welsh Office then provides half the health authority's contribution of 60 per cent. However, there is some flexibility in arriving at the permutation of tapering arrangements which best suits the needs of individual authorities and the circumstances prevailing at any given time. But, as the Health Advisory Service has argued, 'this still does not provide the same incentive for authorities to plan together as does the English system which (by top-slicing at national level) provides sums in the order of £300-400,000 to the average health authority' (Health Advisory Service and Social Work Service of the Welsh Office, 1985, paragraph 27: 5).

1.3.9 The amounts available for joint finance in Wales were relatively small compared with England but between 1980-81 and 1982-83 they were

the same as Scotland on a per capita basis (see Table 3). Thereafter, spending in Wales was considerably more modest than in Scotland and fell in absolute terms in 1985-86. However, further additional sums were beginning to be invested in the All-Wales Strategy by that date. After its first year of operation, 1977, the Welsh system of joint finance resembled that which operated in Scotland from 1980-1985. Joint finance is earmarked centrally by top-slicing from the NHS vote and bids are invited for contributions from this pool. However, in contrast to England, and to Scotland prior to 1985, it is only the central government portion that is top-sliced. Health authorities are normally expected to find 50 per cent of the total NHS contributions from their general allocations.

1.3.10 For the first year of the operation of joint finance the Welsh Office ruled out a central reserve bidding system on the grounds that it 'would necessitate reducing the finance available for general distribution' among health authorities (Welsh Office, 1977, paragraph 12:4). A central reserve, it was argued, would distort local priorities and decisions on the best use of resources. Accordingly, the Secretary of State decided that a health authority's contributions to agreed schemes should be met from its normal allocation. However, the arrangement was short-lived. In 1978 a further circular announced that the situation had changed (Welsh Office, 1978). A central bidding system was established which involved additional new money rather than merely top-slicing from the overall NHS allocation. In this respect arrangements in Wales differed from those in England and Scotland from the second year of

operation of a joint finance system. The Welsh Office adopted a central bidding system in order to permit certain types of development to proceed which would have been difficult to support if the pool had been allocated to health authorities on a pro rata basis.

1.3.11 In 1983, following a period of consultation on the Care in the Community document (Welsh Office, 1981) which listed various options intended to provide incentives to aid joint planning, revised arrangements for joint finance were contained in a circular (Welsh Office, 1983). The changes brought Wales more into line with arrangements in England. The maximum period of joint finance for schemes aimed at enabling people to move out of hospital was 10 years at 100 per cent funding and 13 years of joint funding in all. The scope of joint finance was also extended to housing and education. Special arrangements, as mentioned, applied to the development of mental handicap services and were additional to any initiatives receiving support from joint finance.

1.3.12 There are other mechanisms besides joint finance in Wales to ensure the transfer of resources from hospital to community services. A reordering of priorities within the public expenditure survey in favour of personal social services means that provision in local authority spending is higher than actual spending. Whereas the tapering arrangements for joint finance make some local authorities wary about entering into such schemes, the mental handicap strategy and its funding offer a more attractive incentive. The various

initiatives launched by the Welsh Office have brought additional money to social services departments to the extent that, according to the HAS, 'planning with the Welsh Office has come to assume more significance (in scale) than joint planning between health and social services authorities' (Health Advisory Service and Social Work Service of the Welsh Office, 1985, paragraph 28:5).

1.4 Assessment and Conclusion

1.4.1 What emerges most clearly from a review of joint planning across Britain at both national and local levels is that progress has been limited and uneven. In none of the three countries has collaborative planning achieved the results sought when the NHS and local government were reorganised in the mid 1970s. Comprehensive joint planning for individual client groups has been rare though there are strong indications that, in the case of mental handicap, this is beginning to take off universally in Wales. The efficiency scrutiny mentioned earlier seems to confirm this view. Successful collaborative ventures have, however, occurred more frequently around individual projects especially in England and Wales. In Scotland, on the other hand, where the first circular on joint planning did not appear until 1980, both practice and debate appear on available evidence to be less advanced.

1.4.2 In England, the Progress in Partnership working party is indicative of a reawakening at national level of an interest in joint planning which seemed to wane with the publication of Patients First in 1979 and the subsequent restructuring of the NHS. The report makes

valuable recommendations for strengthening both collaborative structures and accountability processes. Whether it gives sufficient attention to the essentially political skills of inter-agency bargaining and negotiation so vital to successful planning (see subsequent sections) is more doubtful. Arguably, the development and deployment of such skills are critical issues for policy-makers in each of the three countries. Related to this is the need for incentives to encourage joint working. Both the experience of the All-Wales Strategy and of joint/support finance suggests the important contribution of financial incentives. There may also be other incentives such as, for example, managerial changes centring on case management which can make for heightened job satisfaction (Challis and Davies, 1986).

1.4.3 A review of financial incentives across Britain to promote joint planning reveals sharp differences in aspects of their purpose and design. The problems specific to each of the three countries have been mentioned in passing and need not detain us further here. There are, however, some general problems associated with joint/support finance which are common to the three countries. From the start, in Wales and Scotland, joint/support finance enjoyed a lower profile than in England. Not only was it introduced later but the amounts involved were substantially smaller and have remained so. Although each of the countries saw the mechanism as a stimulus to joint planning, the connection was most pronounced in England. In Wales and Scotland, there was a greater emphasis on joint/support finance as a means of initiating new developments on an experimental basis.

This difference in approach appears to be reflected in the more generous and flexible arrangements governing the use of joint finance in England.

1.4.4 Although it has to some extent served as a spur to collaboration and joint planning, the mechanism of joint/support finance has not been devoid of difficulties and drawbacks across the three countries. Three in particular stand out. First, because the amount of joint/support finance to any health authority is limited there are built-in restrictions on the type and scale of project that can be supported.

1.4.5 Second, joint/support finance is designed to taper off at some point until the funding is taken over by the participating local authority. Successive resource squeezes on local government have created additional difficulties in decisions over whether or not to use joint/support finance because of concern that in the longer term it may not be possible to sustain developments which have been given life through this pump-priming mechanism. Joint/support finance can be a double-edged weapon. Moreover, the temptation increasingly is to use this ready source of funds to make up for cuts in main budgets and to shore up mainstream services. Schemes have been put forward which previously would probably have been funded from main budgets rather than from joint/support finance.

1.4.6 Third, it is not always easy to distinguish between schemes which are in the interests of the NHS, and therefore could be expected to make

a better contribution to total care than if the funds were directly applied to health services, and those which are clearly of less direct relevance to the NHS or to health status. The difficulty is that most social services activity involving any of the priority client groups is likely to have implications of one sort or another for health services. Until recently, most schemes put forward for support have been instigated by local authorities and, with few exceptions, health authorities in general have not sought to evaluate the projects funded from joint/support finance or rigorously to assess their expected benefits to the NHS.

1.5 Conclusion

1.5.1 From this brief overview of developments in joint planning and joint/support finance across Britain it is possible to conclude that within a general common policy framework there is great variety and difference between the three countries. While overall progress has fallen short of expectations there has been some. Joint planning may not be universally in evidence but equally it is not completely absent. What, then, are the factors that enable, and conversely constrain, joint planning? What factors are responsible for effective joint planning in those instances where it is in evidence? What scope is there for policy and organisational learning from these examples? It is to a consideration of such issues that this report turns in Sections 3 and 4. First, however, it is necessary to describe the approach to understanding organisational processes which underpins this report and, in particular, the analysis which follows. This is the purpose of Section 2.

SECTION 2 : SOME THEORETICAL CONSIDERATIONS

2.1 Introduction

2.1.1 There is a familiar dictum that nothing is so practical as a good theory. If joint planning is to be better understood and if the conditions under which it operates are to be accurately documented and used as a basis for modifying, or creating, the conditions to allow it to function successfully elsewhere, then it is necessary to subscribe to some theory of how organisations function both internally and across boundaries. Two perspectives are offered here which bring together various bodies of theory. They may be termed respectively 'idealistic' and 'realistic'.

2.1.2 There are, of course, other valid theoretical approaches which might usefully be employed although it is believed that these can broadly be subsumed within the approaches described below. For instance, Bruce (1980) has set out theories of cooperation under the general heading of 'social exchange'. Aspects of social exchange are captured in the discussion which follows. Bruce (1980: 169) argues that 'each party in a cooperative situation makes a contribution to a joint endeavour and each party expects to derive some benefit therefrom'. Political scientists and organisation theorists have put forward the concept of 'policy networks' as a tool for understanding policy processes (Rhodes, 1981). Rhodes has proposed a five point framework to explore policy networks and interorganisational relations.

- Any organisation is dependent upon other organisations for resources.

- In order to achieve their goals, organisations have to exchange resources.

- Although decision-making within an organisation is constrained by other organisations, the dominant coalition retains some discretion.

- The dominant coalition employs strategies within known rules of the game to regulate the process of exchange.

- Variations in the degree of discretion are a product of the goals and relative power potential of interacting organisation.

This framework is useful for understanding the operation of joint planning and, in particular, why it tends to conform to a realistic rather than an idealistic approach.

2.2 The Idealistic Approach

2.2.1 The idealistic approach is usually referred to in the policy-making literature as the rational comprehensive or rational actor model. It presupposes the existence of a consensus within an organisation. Basically, the greater the degree of rationality in an organisation the greater the emphasis on consensus, on harmony, and on a corporate

approach to decision-making. In the context of joint planning, which demands an inter-organisational response, it is assumed, under the terms of the idealistic approach, that organisational altruism is its own reward and will prevail. This assumption can exist either on the part of central government or on the part of local agencies such as social work departments and health boards. Decisions taken within the framework of what Allison (1971) terms the rational actor model reflect a single, coherent and consistent set of calculations about particular problems. The possibility of organisational and political complications fouling the smooth running machine do not enter into the model's ambit.

2.2.2 Joint planning, as conceived by central government, is largely derived from rational theories or, as it is termed here, the idealistic approach. These theories assume a unitary view of organisational relationships insofar as all those involved in joint planning identify with, and share in, a common, superordinate goal, namely, the meeting of individual client needs so that wherever possible, and if this is their wish, individuals may be supported as necessary in their own homes. Tensions, or clashes of interest, are perceived as irrational and are defined as 'technical' problems, ie failures in communication, cognitive reasoning, poor information, mismatched agency boundaries and so on.

2.2.3 The problem is that in Dimmock and Barnard's (1977:102) words the unitary perspective 'has denied the existence of sectional interests and, in consequence, has largely failed to provide an accurate

description of inter-group relationships'. To view organisations as acting altruistically is to assume a naivety which belies what actually happens in practice (Booth, 1983). Organisational rationality is not the same as political rationality. Hence it is necessary to adopt an alternative perspective in viewing organisational processes such as joint planning.

2.3 The Realistic Approach

2.3.1 The bureaucratic politics model (Allison, 1971) views organisational actions not as the outcome of consensus and harmony but as the outcome of a series of bargaining games. There is no unitary mode of action but rather a pluralistic mode, where there is no single strategy for solving a particular problem but many strategies. Under the bureaucratic politics model (BPM), organisations are made up of disparate, decentralised units whose actors perform with different perspectives and priorities. Decisions are reached by much pulling and hauling among these actors and not by a single rational choice as in the rational actor model outlined above. As Dimmock and Barnard (1977:85) put it:

> The pluralist view sees organisations as containing a number of related but separate interests and objectives which must be maintained in some kind of equilibrium. Instead of the concept of a corporate unity reflected in one source of authority and loyalty, there exist rival sources of leadership and attachment.

2.3.2 The authors acknowledge that

> To date the health field has neither admitted nor subscribed to analyses of organisational behaviour which point to the existence of conflicts of interest and the pursuit of sectional interests (p.86).

2.3.3 The BPM perceives decision-making as a political activity, where proposals and decisions are to the advantage of some but inevitably, too, to the disadvantage of others. It also acknowledges the importance of institutional structures within which decision-making is undertaken. Whereas the rational, or unitary, model assumes that these separate structures and interests interlock efficiently in order that a comprehensive and coherent range of instruments can be developed to realise given aims, the BPM views these organisational divisions somewhat differently. They lie in actors having conflicting loyalties rather than sharing an overriding loyalty to the organisation as a whole. In short, if a true understanding of joint planning is to be achieved then it is necessary to be aware of what an American political scientist, Aaron Wildavsky, has termed 'the politics of organisational life'.

2.3.4 As mentioned earlier, it is possible to draw on other bodies of theory and on other concepts which have their origins in political science and the sociology of organisations but all reach similar conclusions. The same applies in respect of the literature on

inter-organisational collaboration (Benson, 1975; Davidson, 1976; Hanf and Scharpf (eds) 1978; Leach, 1980; Norton and Rogers, 1981; Booth, 1983). Organisations endeavour to maximise autonomy and minimise dependency. If collaboration is to succeed the incentives to do so must outweigh the constraints. This is the principal finding to emerge from the review of the literature on joint planning which follows in the next two sections.

2.4 Joint Planning: An Exercise in Naivety or Pragmatism?

2.4.1 Where does joint planning fit into the two theoretical approaches summarised, and slightly caricatured, above? In a sense, both theories apply. The conceptual origins of joint planning undoubtedly lie in the rational actor model (RAM) but the practice of it is closer to the bureaucratic politics model. This is the position taken in this review and lies at the heart of the assessment offered of success and failure in joint planning. Adopting one or other of the approaches delineated above will lead to very different explanations of why joint planning can go wrong or can appear successful.

2.4.2 It is perhaps simplest to illustrate the point with an example. Adopting a RAM, if joint planning is perceived as being problematic, failure will lie in a technical malfunction, eg faulty consultative machinery, poor information, absence of coterminous boundaries and so on. The solution will be seen to reside in correcting such anomalies which are inducing noise in the system. Under a bureaucratic politics model, on the other hand, attention to such matters will at

best help to create the conditions in which joint planning can occur; at worst they will prove to be quite irrelevant.

2.4.3 For those who subscribe to the BPM approach to understanding organisations, problems in joint planning are seen to be political in nature. If, for instance, services for elderly people are not being planned and provided collaboratively across professional, service and agency boundaries because of alleged resource shortages then the BPM approach will account for this lack of progress by demonstrating that other interests (possibly in the acute hospital sector, ie. the 'dominant coalition' which figures in Rhodes' analytical framework cited earlier (see paragraph 2.1.2) have triumphed over the interests of elderly people and their carers. In short, the BPM directs those in search of explaining failure in joint planning in regard to elderly people towards differences in values, goals, the structure of interests within organisations (eg the dominant position of the medical profession in contrast to the much weaker position of social workers) and so on. Exactly the same argument will be used to explain success in joint planning. For advocates of the rational actor model, success will imply that technical problems have been overcome: for those who subscribe to a bureaucratic politics model success will reflect particular constellations of interests which have combined to negotiate, bargain and strike a deal to provide better services.

2.5 Conclusion

2.5.1 It will be argued in the final section of this review that if joint planning is understood in terms of the two approaches described above, and if it is accepted that the practice (or absence) of joint planning owes more to the bureaucratic politics model than the rational actor model, then there are important implications for future policy and for the reform of existing arrangements. For example, it is often alleged that in Scotland the absence of statutory machinery for joint planning (in the form of JLCs) suggests a weaker commitment to joint planning than, say, in England and Wales. Under a pure RAM, the solution would lie in correcting this perceived anomaly. However, under the BPM the explanation would be viewed as being considerably more complex and not susceptible to such legislative tinkering. For a start, the absence of statutory machinery might be regarded as symptomatic of a lower political commitment to joint planning. Merely to put JLCs on a statutory footing would not be seen in isolation to make much, if any, difference to the conduct of joint planning or to the outcomes of such activity. There would need, in addition, to be a commensurate shift in the political commitment to joint planning in order to ensure that the machinery delivered the goods. To achieve success, the BPM would place less emphasis on legislative change and considerably more emphasis on the creation of coalitions and a constituency in favour of change through joint planning. In turn, such a prescription would have implications for the kinds of managerial roles and skills that would be required.

2.5.2 It is not suggested here that either approach - the idealistic or the realistic - is superior to the other. Both the RAM and the BPM are necessary to a full understanding of joint planning. The two models need to be seen as complementary and not in conflict. While it would be quite wrong to overstate the existence of organisational altruism, it would be equally wrong to suggest somewhat cynically that it can never exist. Sectional interests may prevail but they need not do so to the wholesale exclusion of other values which stress, for example, the ethic of service to the client. Notions of power dependence and bargaining can work to the advantage of the user as well as of the provider.

2.5.3 In conclusion, the view taken here is one endorsed by the authors of a major study of joint planning at national and local levels, namely, that 'organisations compete for the resources with the result that the normal mode of coexistence is not harmonious collaboration but bargaining, power play and conflict' (Challis and others, 1988:39). Joint planning as a process is as much a part of this culture as any other aspect of service planning and priority-setting in health care (Haywood and Alaszewski, 1980; Hunter, 1980; Ham, 1981).

SECTION 3: OBSTACLES TO JOINT PLANNING

3.1 Introduction

3.1.1 In this section the more common difficulties encountered in joint planning are identified and, where appropriate, illustrated with examples. As was mentioned in the Introduction, the evidence upon which judgments are made concerning difficulties encountered in joint planning is extremely variable. It was not possible to undertake independent assessment of the evidence. It seems likely, too, that there will be more published accounts of successes than of failures. Few accounts are as thorough and honest as that of Bayley and others (1987:5) which explicitly sets out 'to draw on the lessons of both the successes and the failures' of a locally-based health and welfare project 'so that others can benefit from our experience'. Where examples are cited, references are given. Finally, the literature search, though thorough, makes no pretence at being exhaustive.

3.1.2. The obstacles listed below were those which surfaced most commonly in the material studied. They are also subsumed within Tibbitt's (1982) list. From a review of the available literature it was found that joint planning most often runs into difficulties in situations where:

(i) Planning is non-existent or poorly executed

(ii) The planning timescale is too long

(iii) There is a reluctance to decentralise

(iv) Rigid vertical hierarchies are a feature of agencies

(v) Overlapping services and gaps in provision exist

(vi) Schemes are 'forced on' health authorities

(vii) Joint finance is misused

(viii) There is failure to appreciate that community care can be an expensive solution

(ix) There is a lack of communication between professional groups

(x) There is a gap between professional views and those of clients or their carers.

3.1.3 There is inevitably much overlap between many of these items. For this reason, in the discussion which follows, the points have been grouped under four main categories: planning (items (i), (ii), (iii)); organisation (items (iv), (v)); resources (items (vi), (vii), (viii)); professional considerations (items (ix), (x)).

3.1.4 Many of the obstacles listed are familiar and have been in 'good currency' for some time. They are also reasonably well documented in more general reviews of joint planning notably the working group on joint planning's report, Progress in Partnership (Working Group on Joint Planning, 1985). The report commented on a variety of obstacles to joint planning which were either of a geographical, organisational, or financial nature. In particular, the lack of coterminosity between health and local authorities, and problems over the availability of resources, especially bridging finance, were regarded as major constraints. Other obstacles included: different management structures, methods of organisation and financial systems of health and local authorities; the constitutional differences between health and local authorities; the wide range of services provided by social services departments and their accountability to the local electorate; differences in the pay structures of health and local authorities which can hamper staff transfers; obstacles stemming from the attitudes and relationships of individuals including: different perceptions of priorities, different professional traditions and perceived status, the innate tendency in all organisations to defend territories and budgets, and the natural concern of staff about the effect of change on jobs.

3.2 Planning (Items (i) (ii) (iii))

3.2.1 Where planning appeared generally to be weak within health authorities and social services departments, it resulted in a similarly weak commitment to joint planning. A study of joint planning in two London Boroughs (Korman, 1982) found that there was

no comprehensive review of services provided. The local authority political platform did not support a commitment to service development or major planning exercises. The local authority research and planning section had been cut to save money reflecting the low prioirty accorded such activity. It was also felt that long term planning brought additional problems. In at least one case, it was claimed that the problem with 10 year plans was that there was five years' talking before anything was done followed by a rush to act which resulted in getting it wrong (Feinmann, 1985).

3.2.2 The activity of joint planning was often viewed as remote from service provision (Baker and Hargreaves, 1980). In many cases it was accused of being over centralised. There is some evidence to suggest that joint plans could be distorted or refined by different levels within agencies and as a consequence of professional discretion (Sibley, 1986). The result was a fragmentation of policy. In this particular instance, home care assistants had been employed through the mechanism of joint finance. However, it became apparent that nobody knew what the home care assistants actually did - there was no hard evidence on how the posts were used or on what they were contributing to the care of individuals. More generally, as Smith (1983) reported, at least one social services department believed that with the abolition of the area tier of management from the NHS in England this had resulted in a reluctance to decentralise any matter relating to planning or development.

3.2.3 Decentralising planning decisions was seen to be appropriate in at least one region, South East Thames (Feinmann, 1985). The RHA attached £10,000 per annum to every discharged mentally handicapped patient. A district general manager in the region saw this as a good example of districts having identifiable funds available to them to undertake their own negotiating with local authorities.

3.2.4 Problems with health authorities taking the lead in joint planning centred on inappropriate models of care or schemes being established (Towell, 1985). One scheme, to build a 40 bed hospital, was objected to by one London Borough late in the day (due to the arrival of a new member of staff) on the grounds that hostels and day care should be provided in place of the hospital (Marslen-Wilson, 1982). A study group made up almost entirely of health interests concluded that the scheme was viable. The scheme was then submitted to the RHA for approval as part of the capital building programme. Because the health authority was convinced that the scheme would be approved by the RHA it remained wedded to it despite mounting objections from local authorities who believed it did not meet local needs. A worry at local level, including among parent groups, was that the new unit would simply provide overflow beds for the large long-stay hospitals in the area. Planning on this occasion was most definitely not regarded as joint.

3.2.5 Marked differences in planning cycles and processes between health authorities and social services departments also hindered effective joint planning (Social Services Inspectorate, 1987). Senior

officials in SSDs felt their counterparts in health authorities had a greater degree of autonomy and were freer to plan strategies and individual projects without having to refer back to committees for decisions about details and use of resources. The authorities studied by the SSI in Southern Region had great difficulty nominating successful schemes for consideration. Problems arose in the absence of direction from RHAs to DHAs to encourage collaboration with local authorities. One social services director estimated that it took six hours to brief himself for each joint care planning team meeting which was a considerable input of time. In general, the SSDs felt they had little input into strategic planning which was dominated by the RHA and DHAs.

3.2.6 From the SSI survey only two examples of joint plans between SSDs and health authorities appeared to be successful. One was a scheme for elderly people but investment here meant that other priority groups did not receive attention. A second example, also involving the elderly, owed much of its success to the goodwill of interested members and officers of the local authority and DHA. Moreover, the DHA Chairman had formally worked for the SSD. In conclusion, therefore, the SSI found that a considerable amount of time was invested by social services departments in the planning process without an adequate level of return. Consistent and strategically planned developments for all client groups within each County Council did not exist. Everywhere, inspectors found that authorities could not commit themselves due to the financial implications. As a consequence, agreements with health authorities to meet local needs

tended to be the norm. Even where a strong formal system of planning existed this did not exclude the need for informal networks. A large degree of opportunism existed in arrangements for joint planning with sub-groups often being set up as a specific reaction to pressure group activity.

3.2.7 A major complaint by SSDs, already noted earlier, was that resources freed by the closure of large institutions were being used by health authorities to create mini institutions. Overall, achievements in joint planning were frustratingly small. This point dovetails with Ferlie's (1986a) observation that the scope of planning may be restricted by potential options and choices not getting onto the agenda. Ferlie (1986b) also observed that there was no requirement upon local authorities to produce strategic plans. 'Formal policy-making is still at a rudimentary stage of development' (p.17). As Hudson (1984) points out, it is difficult for SSDs to respond to the strategic plans of the NHS as they are uncertain how local authority services will develop.

3.2.8 In the balance of care project for elderly people in Wiltshire (Borley and others, 1981; Klemperer and McClenahan, 1981; Health Service Journal, 1982) it was suggested that a problem arising from the absence of effective joint planning was not merely underprovision but also overprovision of services.

3.2.9 The Centre for Research in Social Policy (CRSP)/National Association of Health Authorities (NAHA) survey of collaboration in 1984

concluded that not as much had been achieved with joint planning as had been hoped (Wistow, 1986). The NCVO review of joint planning found that financial considerations tended to squeeze out strategic planning considerations (Harding, 1985). Most of what passed for joint planning was a limited range of services which in most cases did not include housing and education. Too much joint planning was focused on negotiations between service providing agencies and on 'tiptoeing through vested interests' (Harding, 1985).

3.3 Organisation (Items (iv) (v))

3.3.1 Problems of organisation lay principally in the rigid vertical hierarchies in health authorities and local authorities which made it difficult to establish effective horizontal working through mechanisms such as joint consultative committees (JCCs) and joint care planning teams (JCPTs). Allied to these difficulties were the problems of overlapping services and gaps in provision. In the CRSP/NAHA survey of collaborative machinery, Wistow (1986) noted that by 31st March 1984 all DHAs which responded to the questionnaire were members of a JCC and that three SSDs were not members of a JCPT. A study of joint planning by the NCVO concluded that generally JCCs were perceived by voluntary organisations as ineffective (Harding, 1985). This was partly a reflection of infrequent meetings and also the domination of JCCs by political considerations or professional competitiveness.

3.3.2 In a study of innovative schemes for elderly people, Ferlie (1986c:17) found that 'managerial and professional hierarchies nearly

always defeated attempts to construct more lateral forms of organisation'.

3.3.3 The operation of JCCs and JCPTs presented major problems. Richards (1980) reported that in many areas JCCs and JCPTs met 'without any attempt to clarify for what purposes they are meeting' (p.23). A Social Services Inspectorate (1987; 1988) study of joint planning found that a large number of meetings of JCCs led to a reliance upon junior staff which caused inevitable delays. There appeared to be no rationale behind the frequency of JCC meetings and no certainty as to whether or not they furthered the achievement of joint planning. DHA representatives outnumbered SSD representatives on JCCs. SSD officials felt that the benefits from JCCs were not worth the time input especially since the ultimate decisions were made elsewhere. JCCs were regarded only as rubber stamps. Moreover, Barnes (1977) found that only a minority of members had a detailed enough knowledge of services to make a worthwhile contribution. A greater obstacle was the diversity between local government and NHS structures. The diversity was most apparent in the area of planning where philosophies conflicted and planning horizons were completely different (see paragraph 3.2.5 above).

3.3.4 In an evaluation of the All-Wales Strategy for Services for Mentally Handicapped People in one of the two vanguard areas - Gwynedd - it was found that differences in the management styles and structures of the social services departments and health authority caused major difficulties (McGrath, 1988).

> The SSD officers frequently found themselves unable to make decisions but expressed the need to refer upwards to senior management. At times there have been long delays in establishing social services policy ... The health authority officers have a greater degree of delegated power to make decisions ... However, the structure of the health authority often means that, unlike the SSD, there is no one health authority voice (p.59).

McGrath concludes that 'given the different structures and responsibilities of these two agencies, inter-agency tensions are not easily resolved' (p.60). Her findings are supported by a team evaluating the overall All-Wales Strategy (Beyer and others, 1986). However, the team concluded an interim review of the Strategy by stating that joint planning represented an improvement on what had gone before. Prior to the Strategy joint planning was described as having been 'stagnant' and 'moribund'. In particular, the lead agency role for SSDs had contributed to progress provided it was not played up which risked upsetting health authorities.

3.3.5 Internal organisational differences were seen to be a problem in some areas especially in respect of political accountability and managerial arrangements. SSD staff were accountable to local politicians while health authorities enjoyed quite different accountability arrangements. As Hudson (1984) points out, the health interests could legitimately feel that the local authority decision-making process was very complex and a major barrier to

collaboration. Local authorities, on the other hand, could claim that the NHS exercised no control over clinicians. For these reasons, it was felt that initiatives involving joint posts between health authorities and social services departments were problematic (eg. Community Living, 1987). It was hoped that by having a single manager run services from both agencies they would end up moving in the same direction thereby easing the transfer of some services from the health authority to the social services department and stopping a duplication of work. However, since it was felt that the new manager would find it difficult serving two authorities there was the prospect that this would cause resentment amongst health service staff.

3.3.6 The issue of coterminosity in regard to health authority and local authority boundaries remains controversial and unresolved. Some commentators believe that its absence creates major problems for collaborative working. In this regard, the 1982 NHS reorganisation in England was felt to have had an unfavourable impact on collaboration due to the removal of the area tier (Hudson, 1984). It is difficult to pin down the precise impact of coterminosity or its absence on joint planning activity. It is more likely to be a case of its absence being merely one of many factors hindering effective collaborative activity. From the available evidence, the mere existence of coterminosity is no guarantee by itself that joint planning will succeed if other factors are not also favourably disposed towards it. In a discussion of factors hindering or aiding joint planning, coterminosity appears neutral.

3.3.7 In Northern Ireland, where joint health and social services boards operate the evidence (such as it is) concerning their efficacy is contradictory. Kelly (1978), for instance, argues that organisational integration does not overcome professional differences. Connolly (1985) also subscribes to this view. Nicolson (1984), on the other hand, maintains that the system of joint boards has many advantages. In particular, a close and constant connection between social services and health services at all levels facilitated joint action; relationships were more informal; flexibility in the use of resources was possible; chief officers representing health and social services met regularly and were responsible for the coordination and planning of health and social services. The structure for planning, in Nicolson's view, was better adapted to inter-disciplinary dialogue than elsewhere in the UK.

3.3.8 Probably both views of the arrangements in Northern Ireland contain some truth. The more unified structure can be expected to aid joint planning since it obviates the need for cumbersome arrangements to be superimposed. On the other hand, professional turf battles are not automatically removed by such actions and these may continue to constrain progress. The theoretical discussion in Section 2 is helpful in understanding the position in Northern Ireland and in accounting for the seeming contradictions in the discussions of joint planning in this part of the UK.

3.4 Resources (Items (vi) (vii) (viii))

3.4.1 Joint finance, or 'collaboration money' as it has been termed, is often regarded as the key to joint planning. Indeed, the two policy instruments are frequently synonymous, with joint planning being seen as concerned principally or solely with the allocation of joint finance. However, it is alleged by its critics that joint finance can be 'misused' in a number of ways although it is not always possible to establish clearly what the problems are. Because joint finance may be seen as the only readily available means by which to extend resources, it can be used to shore up services which would, in the absence of joint finance, either receive funding from mainstream budgets or not be funded at all. In addition, a focus on joint finance tends to result in a somewhat circumscribed and overly narrow view of joint planning. Attention is concentrated on the details of specific bids or projects with little or no attention being given to the overall needs of a particular client group (Sibley, 1986). Joint finance, too, is seen as a way of local authorities getting access to additional resources from the NHS which, while boosting the coffers of SSDs, may contribute little to joint planning.

3.4.2 As Wistow (1987) has pointed out, under the terms of joint finance (see Section 1 above), NHS interests ought to have been the dominant influence in shaping its allocation. 'In practice, joint finance was harnassed to NHS priorities in only very limited and indirect ways, certainly until 1983' Wistow (1986:87). Wistow reports that case studies in individual localities have shown the health service to have minimal influence over the design and selection of projects for

joint finance. 'As a rule, projects emerged from local authority decision-making and priority-setting processes: the NHS role was confined to the all-but-automatic endorsement of such proposals' (Wistow, 1986:87). As was reported in paragraph 1.2.19 above, the position shifted in later years with health authorities spending increasing proportions of their joint finance allocation on health service developments which, while putting them in charge of the fate of joint finance, was a distortion of the policy instrument's original purpose.

3.4.3 Another problem has been that joint finance has become peripheral to the many negotiations between local authorities and health authorities because the sums available are only sufficient to support very small schemes or project posts (Social Services Inspectorate, 1988). This view is confirmed by a study of community care in six areas (Gray, Whelan and Normand, 1988). The total sums of joint finance involved averaged no more than three per cent of the identified total spending on the client groups by DHAs and local authorities and ranged as low as one per cent. The researchers argue that it is difficult to see how such small sums can significantly influence progress towards community care.

3.4.4 In an analysis of joint finance in seven non-London health authorities, Gerard (1987) observes that a criticism of it lies in the transitional costs necessary to support two parallel services as the balance of care shifts. A scale of financial support is involved which joint finance alone cannot cover. Gerard concludes that joint

finance has a definite role but a narrowly circumscribed one because it is insufficiently flexible. Moreover, the present rules over the disbursement of joint finance act as a disincentive to local authorities due to controls over local government expenditure. Projects also tend to be recycled and resubmitted for joint finance if unsuccessful on the first round rather than new schemes being brought forward as appropriate.

3.4.5 There is also a built in tendency for joint finance to be used for capital projects which have no revenue consequences, or short term revenue projects. For example, Townsend (quoted in Kelly, 1978) has said:

> The joint finance scheme seems to be adding to the pressures to institutionalise larger sections of the population, or at least provide an alternative form of institution to those who would previously have been cared for within the hospital system.

3.4.6 Joint finance does not encourage community care projects due to the long term revenue consequences for local authorities creating a bias towards capital developments and, as a consequence, residential institutions. Townsend (1978) claims that this is a particular problem in London and the South East. Longer term commitments tend to be only revenue projects and these mean revenue pick up in later years which can cause problems for local authorities especially if there is zero growth in social services.

3.4.7 A further problem is the imbalance between joint planning effort and a joint finance scheme which may be unfavourably disproportionate to the contribution the scheme makes to a community care programme. There is also growing concern, and in contrast to earlier developments (see paragraph 3.4.2 above), that joint finance is increasingly being used for new health service schemes to bring people out of hospital rather than on social services schemes for those already in the community (Harding, 1985). It has also been the case, as Gerard (1987) found, that joint finance is dominated by social services departments and health authorities. Progress towards wider collaboration involving housing and education departments has been slow. Joint finance, in Gerard's view, has not been used in a particularly innovative way.

3.4.8 McCarthy (1986) found that joint finance posed a number of problems. In particular, social services departments were disadvantaged in the take up and use of joint finance because it was not related to an overall planning strategy but used in a piecemeal way (see paragraph 3.4.1 above). Health authorities were initiating schemes that should be the concern of local authorities but, due to the system of local authority funding, they were not taking up joint finance.

3.4.9 As Green (1986) points out, joint finance is a way of picking up short term costs although the main costs are long term. He believes that joint finance has induced mistrust among health authorities who are convinced local authorities are spending their allocation on other services and not on agreed projects of benefit to the NHS.

Although there are many and increasing drawbacks to joint finance, there is no doubt that it is has enabled a variety of initiatives to be launched. Some of the positive aspects of joint finance, and the uses to which it has been put, are reviewed in the next section.

3.4.10 Other financial incentives exist to stimulate joint planning besides joint finance. Many have been devised to cope with the problem of moving resources when a patient moves from one form of care to another. Wistow and Hardy (1985) provide a number of examples of how different areas have coped with this problem. For instance, North Western and Trent RHAs have established regional pools, or 'bridging funds', from which dowries are paid to accompany every patient moving from hospital to the community. The maximum dowry in North Western RHA stands at £11,300. In Trent it is £12,000. These figures are based on average costs for keeping a patient in a long stay hospital (1985 prices). North East Thames has no equivalent arrangement but has two discrete but complementary mechanisms. First, there is a revenue adjustment scheme which redistributes resources to all districts by adjusting the cash limit of the receiving district by the amount it costs to keep patients with a notional residence in the district in long stay hospital. This amount is between £7,000 and £17,000. It gives a planning total which become permanent when the patient is transferred. Second, transitional costs are met by a separate resource pool. North Western RHA does not distinguish between receiving agencies - whether they are local authorities, health authorities, or voluntary bodies - since all get £11,300 per patient. Trent and North East Thames RHAs only give health

authorities the maximum sum. Trent only gives a maximum of £6,000 to other agencies on the basis that they can claim social security benefits. North East Thames will give up to the cost of a hospital place providing districts are willing to supplement the sums transferred from other sources. However the amounts are calculated and allocated, they may still be insufficient to support highly dependent clients in the community.

3.4.11 A model of a rather different kind is the Welsh Office's All-Wales Strategy for the development of services for mentally handicapped people introduced in 1983. It is an accelerating 10 year plan to invest new resources and services for mentally handicapped people. Because new resources are available there is no need to rely upon dowry payments or other financial mechanisms.

3.4.12 Clearly, on the basis of Wistow and Hardy's (1986) evidence, RHAs are in a strong position to structure local policy environments in such a way that they can hinder as well as promote the transfer of resources. Local authorities appear to be impotent to modify the situation and can do little else but respond to the whims of the regions. It is not surprising, therefore, that local authorities feel excluded from policy decisions or that DHAs may not find the incentives sufficient to make progress locally. In contrast, the Welsh Office emphasis on preventing new admissions rather than emptying beds with a lead role for local authorities plus additional funds to enable services to be developed may well be a model to follow although it is not without its difficulties when it comes to

implementation for reasons stated earlier in this section (see paragraph 3.3.4).

3.5 Professional Considerations (Items (ix) (x))

3.5.1 Interprofessional difficulties and differences are often cited as being at the centre of problems over communication and effective joint planning. In particular, relations between social workers and doctors appear to be uneasy and unproductive. Yet, as Malin (1984) has pointed out, along with other commentators, good communication is important for sharing cases between agencies. Malin found in his study of contacts between social services departments and primary health care teams carried out in Sheffield that workers had stereotyped views of each other and collaboration was minimal. As Ferlie (1986b) notes, the problem can arise because of different work models and practices between professions and agencies. At the root of the problem is the absence of a common purpose uniting service providers.

3.5.2 In a pilot project designed to break down the communication barrier in community care carried out by Leeds Health Authority and the relevant local authorities, the most important finding was the urgent need to establish effective communication between services and professional groups (NAHA News, 1984). It was found that health workers and social workers were frustrated by their lack of understanding of each other's roles. The existing structures tended to militate against improved understanding and attempts to cross boundaries were often met with suspicion. Health workers' and social

workers' roles were unusually close which often led to duplication of services or to unintentional negligence as it was not easy to know who should do what.

3.5.3 Problems in communication underlay the move in Newcastle by the joint care planning team to establish a partnership between the health authority, social services department, voluntary agencies and housing department in regard to services for mentally handicapped people (Roycroft, 1983). Existing services were seen to be good in overall terms but there seemed to be no strategy. The aim was to identify the mentally handicapped at birth and ensure that a service was in place to support them and their families throughout their lives. The joint care planning team found that professionals themselves were amazed that they knew so little about each other and their respective roles and functions. The intention was to promote better communication between professionals and to give parents and relations of mentally handicapped people a clearer understanding of what was available and the functions of the various services. The partnership was comprised of equal numbers of representatives from health and local authorities, parent groups and voluntary agencies.

3.5.4 In a study of professional collaboration and services for mentally handicapped people, Ferlie and others (1984) studied the work of multidisciplinary teams for mentally handicapped people in two health districts. In district A, the Community Mental Handicap Team and the Mentally Handicap Health Care Planning Team were investigated. In district B, a Mental Handicap Working Group and a Child Health Care

Planning Team were studied. District A saw the role of its groups as, inter alia, enabling the work of all the agencies serving mentally handicapped people to be coordinated. Case conferences for all new cases were held so that the decision as to which agency would best deal with the case was discussed and a key worker identified. In district B, the teams were concerned with policy and planning rather than direct service provision. Parents were asked if they had heard of the teams in either district and 91 per cent had not. Only five per cent knew what the role of a team was. A booklet had been produced to explain the teams but it did not make clear how a family could approach such an entity unless referred by specialists. Moreover, 51 per cent of the sample said that they had not received a booklet. The researchers concluded that parents were confused about what was available and were unable to make the best use of services. Although this study was not concerned with joint planning as such, it demonstrates the problems of interprofessional joint working as seen by users.

3.5.5 Apart from problems arising from attempts at horizontal communication across agencies, problems of communicating vertically within organisations were also evident. For instance, the evaluation of the All-Wales Strategy in Gwynedd identified a gap between frontline staff and managers which was reflected in feelings of distance, lack of involvement and powerlessness (McGrath, 1988). Similar difficulties were encountered in a study of pathways into care followed by elderly people in two areas in Scotland (Hunter, McKeganey and MacPherson, 1988)

SECTION 4: FACTORS FACILITATING JOINT PLANNING

4.1 Introduction

4.1.1 Murphy (1987) has said that with all the obstacles arrayed against it, it is a wonder that joint planning suceeds at all. Yet it does. Even the Audit Commission (1986), in its critique of community care policy, conceded that joint planning could work and cited examples accordingly. The review of the literature conducted for this report also provided examples of initiatives where joint planning had succeeded. One of the problems, however, in assessing whether joint planning has been successful is the lack of hard evidence on effective outcomes.

4.1.2. From the evidence obtained, joint planning is more likely to suceed when:

(i) time is invested in it and there is input from all the agencies concerned

(ii) information is produced on existing services and on identifying where the gaps are (ie, where background research and evaluation is carried out)

(iii) regular reviews of progress are completed as an initiative develops to ensure its stays on the right track

(iv) developments are kept manageable (ie, small) and are not over-ambitious

(v) working groups prepare the ground and develop proposals

(vi) key workers are appointed

(vii) joint finance is available

(viii) informal relations between agencies are well developed to allow continuity of thought and practice

(ix) there is an adequate support system in the community.

4.1.3 To aid the discussion of these factors in the remainder of this section, it is more convenient to group them into the four categories employed in Section 3: Planning (Items (i), (ii), (iii), (iv)), Organisation (Items, (v), (vi)), Resources (Item (vii)), Professional Considerations (Item (viii)). The last item listed above (ix) does not fit into any of the categories yet it was found to be important in successful joint planning. Where there was widespread public opposition to community based services, or where parents or groups of carers were unwilling to assume responsibilities then it made it more difficult to move forward on options which involved developing domiciliary based care options.

4.2 Planning (Items (i), (ii), (iii), (iv))

4.2.1 Effective joint planning can take time. Payne (1984) describes a project to establish a development officer post in North Wales to promote and expand the mental health voluntary movement. The project involved the Welsh Office, two Social Services Departments, two Health Authorities, and MIND. A five way arrangement was negotiated with the project ultimately being run by MIND in partnership with the funding agencies. Negotiations took two years to complete. The project was seen by the Welsh Office as a model to promote partnership between diverse agencies involving both the statutory and voluntary sectors. The time and commitment invested in policy formulation and liaison helped to make the development a reality. Staying power and commitment were vital ingredients in the successful realisation of the project. Bayley and others (1987) also stress the importance of time - a 'vital ingredient'.

4.2.2 In a review of 12 innovative initiatives in the care of the elderly, Ferlie (1986c) considers the respective merits and demerits of the schemes which were centrally sponsored (top-down) and locally sponsored (bottom-up). According to Ferlie (1986c:17):

> The main problems with top-down innovation relate to implementation difficulties, especially the negotiation of new roles and styles of working among resistant staff, while bottom-up innovations find difficulty in securing resources or referrals because of the lack of organisational legitimacy.

As Ferlie concludes, it is not enough for change to happen; the change process should be aligned with strategic objectives and demonstrate signs of efficiency improvement. Moreover, in order to secure the necessary legitimacy it is important for higher levels of the sponsoring agencies to be seen to be supportive of the initiative.

4.2.3 Locality planning is increasingly viewed as a way of bridging the gap between strategic activity on the one hand and operational activity on the other. Given the vacuum that can all too easily occur between strategic and operational planning respectively which can lead to problems over implementation, locality planning is seen as a possible solution. Exeter is the home of locality planning and it has been employed there with apparent success (King and Court, 1984). According to Phillips and Court (1982), its greatest strength lies in its ability to become whatever the local community wishes. Within Exeter a series of locality meetings gave rise to 100 suggestions from staff which were condensed to 40 that were then followed up by working groups. Phillips and Court sight the main achievements as being:

- staff taking up new contacts and solving problems on their own

- joint training of health and social service staff in the care of the confused elderly

- NHS nurses helping social services occupational therapists by delivering aids to patients for them

- community psychiatry nurses based in localities rather than centrally

- plans between health and social services for the joint use of confused elderly and geriatric beds in social services premises

- nurses, voluntary agencies, and home helps sharing resources to care for people out of hours

- future community planning by groups of professionals rather than unilaterally, eg, joint planning of the location of new geriatric bed capacity.

Devolved planning along the lines of locality planning has taken root in many other places across England and Wales. A possible drawback or limitation of the Exeter approach is that it is health-led with no significant input from social services. However, since developments in locality planning are akin to patch working in social services there may be scope for linked developments (Dalley, 1987).

4.2.4 A study of collaboration in respect of the frail elderly found that collaboration could succeed if objectives were clear before attempts were made to collaborate; if specific areas for collaboration were concentrated on rather than trying to spread activity too thinly;

and if enthusiasm was present (Lord, 1983). The study also found that successful collaboration at a strategic level had important effects on collaboration at other levels. In most areas, officers seemed to be the focus for collaboration. In addition, personalities had a major impact on success.

4.2.5 In the Wirral, joint planning between the health authority and local authorities has been evolving successfully since 1975 in respect of care in the community and mentally handicapped people (Murphy, 1985). The intention in 1975 was to set up structure in order to consider the needs of each care group which would comprise representatives from health services, social services, education and housing. Shortages were identified by producing a service profile eg, mentally handicapped profile, which showed a shortage of special care places for highly dependent patients in adult training centres. Also, shortages were found to exist in adult training facilities in one area which had led to a local authority school that was surplus to requirements being converted. The service profiles also revealed the need to introduce homes for elderly people and meals on wheels.

4.2.6 The balance of care project for elderly people in Wiltshire has provided a framework for promoting joint planning (Borley and others, 1981). A joint management team (JMT) and professional advisory group (PAG) are the principal means by which planning is carried forward. The JMT was made up of assistant directors of the social services department and the directors of housing. The PAG was chaired by a GP with two consultants, two divisional nursing officers, housing

manager, a home help organiser, a social work team leader, and a development officer for residential and day care. The PAG sets up a care framework with the intention of eliminating service overlap and providing packages of care. The JMT manages the entire structure.

4.2.7 In Stockport, problems in joint planninng were tackled by establishing a chief officers' panel, an area planning team, and a joint research and intelligence unit. These were in addition to the joint consultative committee (JCC) and the joint care planning team (JCPT). The chief officers' panel was made up of the health authority's management team and the councillors' management board which met to 'shadow' the work of the JCC. It met three weeks before each JCC meeting to consider progress from previous meetings and issues to be discussed. It had a wide remit dealing with planning and operational matters. The area planning team comprised three health authority officers with special responsibility for planning as well as members from the council and members from the social services. They advised on planning. The joint research and intelligence unit was part of the local authorities corporate planning unit within the chief executive department.

4.2.8 Wilson (1977) maintained that several changes could be made to improve the framework within which joint planning took place in Stockport. There ought to be more freedom for health authorities to adjust their planning systems to fit local circumstances; to strengthen the system, especially at district level and with all the agencies that participated in planning; to redirect research towards

interrelations and problems of services; to realign the planning timetables of local authorities and health authorities and to encourage local authorities to develop their own longer term plans.

4.3 Organisation (Items (v), (vi))

4.3.1 The most successful organisational arrangements for joint planning appeared to centre on joint management or partnership arrangements like the Newcastle initiative for mentally handicapped people or some mechanism which complemented the joint consultative committtee/joint care planning team structure. Another good example of a jointly managed initiative is the NIMROD (New Ideas for the Care of the Mentally Retarded People in Ordinary Dwellings) project in Cardiff (Bayley and others, 1984). Delegating management responsibility was important in ensuring that action occurred in various schemes. For instance, in West Cumbria a scheme for mentally handicapped people was run by a board of trustees and an association responsible for the management and employement of staff who had a choice of being employed by the health authority or social services department and therefore adopting that particular agency's conditions of service and salary scales. One member from each of the four organisations - the health authority, the local authority, local MIND organisations - was on the board of trustees. The board was established in 1987 and had 13 staff in the community which had led to improved communication in planning. Ultimately it was hoped that the association would have sole control of all housing for mentally handicapped people in the community, staff training and day care.

4.3.2 In Lewisham, the health authority and social services department combined to set up a resource centre for community adult mental health care (Bumstead, 1985). The spur to action was the pending closure of a long stay hospital and the absence of community based services to cater for discharged patients. The proposal was submitted to the social services committee for consideration with deinstitutionalisation as its primary aim. Joint funding was secured to permit the opening of a house provided by the borough housing department for existing houses, to serve as a home for the centre. A managment steering group made up of representatives from the health authority and social services department was established to monitor services at the centre and liaise with the staff team. It reported directly to the joint consultative committee. Each client was to have a key worker. The aim was to establish to research project over the next three years to monitor and evaluate the centre.

4.3.3 Bayley and others (1987) point to the difficulties of achieving genuine joint management as distinct from good consultation. The difficulties are particularly acute for SSDs since committees cannot delegate their duties thereby surrendering their accountability. Nevertheless, such obstacles are not insuperable given the examples that do exist.

4.3.4 Case managers and/or all key workers are increasingly seen as vital to the successful achievement of joint planning. Many examples of case management, such as the Kent Community Care Project (Challis and Davies, 1986), replicated in Anglesey and Gateshead, are concerned

only with social services and not health services (and vice versa) (Hunter (ed), 1988). However, there are examples of case management schemes which aim to integrate health and social services provision at the client level. The Darlington Community Care Project for the Elderly is one example (Stone, 1987; Challis and others, 1987). The aim of this domiciliary care scheme, which utilises home care assistants, is to enable people to remain in their own homes. The project has been jointly planned by the health authority and social services department and is managed by a joint coordinating group comprised of senior managers from the two departments. The service managers are responsible for planning and implementing a care plan for individual elderly people. They link up all necessary resources, both formal and informal, target these on the client, monitor the overall efficiency of the support network, and generally act as 'progress chasers' in respect of individual elderly people. The service managers are seen as workers who can cross the traditional boundaries between health, social services and the voluntary sector. Finally, there are examples of independent case management initiatives like the Camden case manager project in which the case managers relate to both health and social services and other services as required. In these independent schemes case managers act as client advocates or representatives (Hunter (ed), 1988).

4.3.5 In Eccles, a multidisciplinary team was established by the Salford JCPT with the aim of helping elderly people to greater independence (Riordan and others, 1988). The team's membership cut across professions and agencies. A part-time coordinator was appointed as

a member of the team in October 1985. The team has been fully operational since April 1986. The team saw its role as not to provide new services but to look at ways in which the quality of service being offered to individual clients might be enhanced through improved interprofessional collaboration. Assessing the success of the team remains to be determined in terms of improved outcomes for elderly people. However, it is claimed that the project has brought benefits to the way in which services function. In particular, the key worker role was an important innovation and barriers were removed between providers and agencies. Nevertheless, it is recognised that these developments should not be regarded as ends in themselves which is often a danger of such initiatives.

4.4 Resources (Item (vii))

4.4.1 It was pointed out in the last section that joint finance was neutral in terms of either hindering or helping joint planning. There are those who believe joint finance has distorted joint planning and reduced it to the level of supporting specific projects rather than developing innovative strategies and service development. On the other hand, joint finance has been seen as essential in meeting the start-up costs for particular schemes.

4.4.2 Korman (1982) points out how important joint finance was in getting a home care scheme established to ease pressures on residential homes and hospitals in a particular area. However, as she points out, joint planning could not be said to have succeeded in overall terms. Korman's finding is in line with the view of the Social Services

Inspectorate (1986) which concluded that most successful joint planninng took place on an opportunistic basis rather than on a longer term, strategic basis.

4.4.3 Gerard's (1987) analysis of joint finance showed how instrumental it had been in pump priming the development and improvement of day services, respite services, and primary health services for elderly and mentally handicapped people. Gerard found that joint finance had a definite role but it was limited by the size and structure of the joint finance budget. Domiciliary based developments dominated in areas of service provision for groups already living in the community requiring long term care, or for those considered at risk of future hospitalisation rather than for the direct transfer of people from long stay hospitals. Gerard thought that the role of joint finance could be extended in the future to provide for other priority groups, especially the mentally ill and physically handicapped who tended to be ignored by joint finance. Gerard concluded that although the joint finance allocation was small it was nevertheless important.

4.4.4 Challis and others (1988) point to the 'mixed blessing' nature of joint resource pools (most notably of joint finance). They argue that as a source of additional resources (and often the only growth increment to SSDs' budgets) joint finance had an incentive effect - at least in the short term. They go on to say (Challis and others, 1988:243):

> if joint finance was not a 'provider of goodies' in anything other than an opportunistic and ad hoc mode, nonetheless most actors' accounts of collaboration stressed the wider benefits which were consequent to agencies being 'forced together' by the due process of joint finance. The need to meet in order to discuss joint finance arrangements and proposals typically brought the wider benefit of increasing mutual understanding and empathy for the problems of resource dilemmas confronting other agencies. 'Scapegoat and adversary positions' were at least reduced. The following observation is typical. It epitomises the nature of the benefits of joint finance, and their limited quality. 'Joint finance has given joint planning teeth, though it has caused problems and also had benefits ... The advantage is a simple one: it has enabled us to give effect to some aspects of joint planning, it has allowed it to take off.'

The authors conclude that joint finance served essentially as a catalyst to existing aspirations or practices rather than as a source of great innovation in its own right.

4.5 Professional Considerations (Item (viii))

4.5.1 Effective joint planning and joint working is dependent upon good inter-relationships. Where informal relationships between health and local authorities existed, it led to continuity of planning and to successful initiatives. According to Murphy (1985) such factors were

important in achieving success in the Wirral. In the example of the multidisciplinary team for the elderly in Eccles, a period of discussion and team building proved essential for the developments which followed (Riordan and others, 1988).

4.5.2 Ferlie (1986c) noted from the findings of a study of community care services for elderly people that in six of the innovative schemes, new roles were created which crossed the boundary between the domestic care tasks of home helps and the basic nursing tasks provided by nursing auxiliaries. The primary qualities expected from such work were personal ones of flexibility, reliability, and initiative rather than formal or technical skills. According to Ferlie, improved joint working was likely to be essential to the achievement of a shift of objectives and to ensure that problems arising from unplanned discharge, 'revolving door' readmissions and a failure to meet multiple needs did not occur.

SECTION 5: POLICY IMPLICATIONS

5.1 Introduction

5.1.1 This final section of the review of joint planning draws upon the preceding analysis of factors obstructing or assisting joint planning in order to assess their implications for future policy. Even where joint planning has been successful, the gains are modest and the investment of time and other resources can seem to those involved disproportionate to any subsequent gains. This is a particular concern among social services departments (Social Services Inspectorate 1987). According to the SSI (1987, para 5.7:15) inspection, 'the elaborate structure of meetings, committees, groups and sub-groups has often had only limited success in fostering any commonality of purpose in the planning of services. Undoubtedly it works with more success in some areas than in others'.

5.1.2 There is a major difficulty in deriving policy implications from the evidence available since so much of it is of a highly variable quality. Basing a review such as this on a perusal of the available literature has limitations where that literature is itself rather uneven and lacking in conceptual or analytical rigour. At the level of individual schemes, there is a virtual absence of any attempt to systematise and structure the accounts in order to provide comparable information. A different type of study involving a longer time scale would have been necessary to obtain information in such a form. On the other hand, there is a remarkable convergence in the literature

upon those factors which appear to act as barriers to joint planning and those which facilitate it.

5.1.3 A further limitation of the available material is that joint planning is invariably viewed from the perspective of health services. Indeed, the work of the SSI in the Southern Region was in response to complaints from directors or social services about the difficulties of joint planning and collaboration with the NHS. Most of the directors in the eight SSDs complained about the lack of cooperation from health authorities and two told inspectors that they would be investing very little in joint planning and collaboration in future unless the staff of DHAs showed more willingness to talk openly and respond to overtures about closer cooperation in the provision of services. While any reference to the Griffiths proposals for community care has been intentionally resisted, there are implications in what is proposed for the future of joint planning. In this context, the problems cited in this paragraph are especially acute.

5.1.4 Notwithstanding the complexities of joint planning, many of which are highly context-specific in their myriad manifestations, there are important implications for policy in respect of social services in the material presented in Section 3 and 4. At the end of the day, what accounts for agencies being either 'sleepers' or 'thrusters' when it comes to joint planning requires further attention possibly from a more anthropological perspective than that adopted by much research in this area. Ferlie's (1986d:21) hunch is that

the shadow informal tier of organisation reflecting history, work norms and locally generated patterns of cooperation and conflict would have more explanatory power than measures of formal structure or the changing balance of needs and resources.

5.1.5 In keeping with the format employed in Sections 3 and 4, the policy implications are considered under the same four headings: Planning, Organisation, Resources, and Professional Considerations. Not all the points fit neatly into one or other of these categories but they provide a useful means of structuring the material.

5.2 Planning

5.2.1 The importance of planning at both formal and informal levels was a constant theme in the material reviewed. For instance, a key concern to emerge from the Social Services Inspectorate inspection of eight social services departments was that even where a strong formal system of planning existed it did not preclude the need for informal networks (SSI, 1987). Equally, the absence of informal networks did not mean that the formal system had a better chance of working well.

5.2.2 According to the SSI, it is often the informal system and opportunistic approach of members and officers in authorities that has enabled advances in joint planning and collaboration to occur. As the Inspectorate concludes, 'they should be seen as indicators of how and where there could be closer collaboration and planning in

future in spite of the disparate nature of the health service and local authority SSDs' (SSI, 1987, para 5.7:15).

5.2.3 If a pragmatic approach to joint planning is the reality, it is probably also the most that can be hoped for. The two contrasting theoretical approaches to understanding interorganisational relationships set out in Section 2 add confirmation to this conclusion. While adherence to the naive, or idealistic, approach would regard joint planning in rather grandiose terms, this can be counter-productive if it prevents opportunities for joint action being seized upon as they arise. Hence the value of a pragmatic, or realistic, approach. If it is accepted that it is not possible for health authorities and social services departments to merge, it is also acknowledged that it is not feasible for the two services to work in isolation of each other.

5.2.4 The evidence reviewed in the two preceding sections essentially confirm the conclusion reached by Challis and others (1988:269) on the basis of their research findings. The researchers

> found inter-agency arenas to be largely characterised by limited and conditional interaction rather than by frequent and free relationships; by attempts to resolve existing problems rather than to anticipate future ones; and by relatively small scale and isolated examples of 'ad-hocery' and opportunism rather than coherent and consistent implementation within some grand design. More

> specifically, the potential gains of coordination for clients or systems had to compete... against such organisational imperatives as budget maximisation, maintaining autonomy and professional self-interest. And while those who stand to gain from the successful outcomes from coordination usually are a diffuse and unorganised constituency, those who stand to gain from the maintenance of the status quo are by definition concentrated and organised.

5.2.5 Given the reality described by these researchers and by others, the message is not to continue the search for some illusive nirvana but to modify and manipulate the reality which exists in order to make progress in joint planning.

5.3 Organisation

5.3.1 Many of the most successful examples of joint planning emerged from structural innovations which by-passed or were loosely accountable to joint consultative committees and joint care planning teams. On their own the evidence demonstrates that JCCs and JCPTs have achieved little largely because of the constraints imposed by the power of vertical hierarchies at the expense of lateral linkages. The successful organisational forms cited have centred on management partnerships, multidisciplinary teams and other devices which not only crossed agency and professional boundaries but which also had executive authority delegated to them in order to make more rapid progress in the development of integrated approaches. Within these

organisational forms, single joint service managers, case managers or key workers were all important devices to overcome boundary problems of one sort or another.

5.3.2 Challis and others (1988) write of the importance of tacticians in taking advantage of the opportunities which present themselves to achieve joint working. Tacticians, or 'responsible schemers' (Friend, 1977), tended not to be at the very top levels of either health authorities or social services departments but were more likely to be located in the second or third tier positions, centrally located and involved in policy development. Most important, they were still in touch with, and aware of, the difficulties presented at an operational level for single service running and the potential advantages to be gained from a joint approach. According to the researchers (Challis and others, 1988:213):

> tacticians were found within Central Planning Units, often acting as self-proclaimed reticulists...What they shared and often recognised in each other was an ability to locate problem areas in policy development and the position to mediate between a top-down and bottom-up approach to policy formation. Sensing the up-down thrust they moved horizontally into collateral agencies in any of the three arenas in an active attempt to solve problems.

Elsewhere, reticulists have been referred to as networkers, as people who endeavour to blur organisational and professional

barriers by creating and nurturing linkages between organisations and professionals (McKeganey and Hunter, 1986). Typically, reticulists operate on the margins, or in the interstices, of organisations.

5.3.3 As was mentioned in earlier sections the importance of enabling structures, like common boundaries, and particular machinery, like joint consultative committees and joint care planning teams, was limited. They were unable by themselves to secure progress and were only an aid to joint planning where there already existed a commitment to such activity. As Challis and others (1988:207) conclude

> common boundaries and organisational structures do not necessarily generate high levels of coordinative output and they are associated with different levels of interest and endeavour in the coordination of social policy ... In other words, machinery is not a sufficient condition for effectiveness in coordination. However, it does appear to produce higher levels of output than informal processes alone.

If joint planning is to be anything other than pure 'ad hocery' then the need for structures of some kind cannot be dismissed out of hand. But the important point is that it is the *combination of factors* that seems to be important in securing progress in joint planning and not the existence of any one in isolation.

5.3.4 According to the efficiency scrutiny carried out for the Welsh Office by Kilner (1987) joint consultative committees suffer from inherent weaknesses. The scrutiny concluded that the JCC mechanism itself, as opposed to some of its sub groups, did not now have a real role to play in forwarding community care. The weaknesses were identified as lying in the purely advisory role of the JCC; the lack of autonomy enjoyed by its members who were answerable to their parent authorities; and the breadth of the issues covered and diversity of interests represented made it difficult for the JCC to focus knowledgeably on any one particular issue. Kilner concluded that there was no reason for JCCs to continue to operate in areas where the field authorities would prefer some other arrangement.

5.3.5 According to Kilner, removing JCCs would offer several advantages: a small financial saving; the streamlining of the present rather cumbersome system within authorities engaged in joint planning; freeing up the planning process which would demonstrate a more action based approach; and, perhaps most important, giving authorities freedom to choose their own arrangements which would permit sensitivity to local realities. For Kilner, the important role for the centre was to focus on the fruits of inter-authority collaboration rather than indirectly on the mechanisms and structures by which those fruits would be produced. Providing the end product met the criteria established centrally for community care policies it should be for authorities locally to set their own arrangements for producing them. Perhaps not unexpectedly, the Welsh Office

felt unable to accept the abolition of JCCs. They were too useful in providing a communication channel between centre and periphery. Nevertheless, the Welsh Office conceded the key criticism that JCCs operated with variable effectiveness.

5.3.6 The Social Services Inspectorate (1988, paragraph 1.9.2:3) shared Kilner's view. In its study of the NHS/SSD interface, it concluded that 'the existence of the JCC was not seen as crucial to the achievement of either joint strategic planning or effective operational collaboration'. This was especially true in cases where one JCC covered a single SSD and several DHAs.

5.4 Resources

5.4.1 The role for financial incentives like joint finance in furthering joint planning is disputed. There is evidence to suggest that it is sometimes a substitute for joint planning or distorts this activity since attention is confined to assessing bids for access to this resource pool. Attention is therefore diverted from examining the purposes to which mainstream budgets are put.

5.4.2 The balance of opinion seems to be in favour of retaining joint finance - warts and all - on the grounds that it possesses many positive features. As Wistow (1987:89), echoing others, states, joint finance 'purchased greater levels of community services and collaboration than would otherwise have been possible...generally speaking, inter-authority joint working increased in the second half of the seventies and joint finance was an important enabling factor

in this process'. Wistow points out, however, that whatever the gains they were limited compared with the level of collaboration which central government has sought to encourage.

5.4.3 Kilner (1987), in his Welsh Office Community Care Efficiency Scrutiny, is also critical of the value of joint finance. In his opinion, it suffered from 'very real weaknesses in its practical application' (Kilner, 1987, para 3.64). These centred upon the size of the programme (1/30 the size of the English scheme - see Section 1 above); the ambivalent attitude towards it by field authorities; and the complexities of the bidding process - 'joint finance is a very elaborate method of transferring money from the NHS to local government' (Kilner 1987, para 3.73). Moreover, in Kilner's view, there is little slack in NHS resources to permit such transfers to be effected painlessly. Transfers might more appropriately be from social security to social services. Perhaps the most important weakness, according to Kilner, is the lack of clarity over what joint finance adds. Certainly counties would claim that the schemes they support for joint finance are projects they wanted anyway - 'though they admit that without central funding they would not have been brought forward so quickly' (Kilner 1987, para 3.71). As Kilner and others have reported, joint finance can represent a cheap source of capital but since many community care developments do not hinge upon such expenditure this can introduce a bias in the type of developments receiving joint finance support. Most community care developments require long term revenue funding. Unless local authorities are reconciled in the long run to meeting the revenue

costs, then joint finance's appeal is virtually limited to representing a cheap source of capital. For the reasons mentioned this carries with it just as many problems as it does potential advantages.

5.4.4 Other financial incentives, notably the 'care in the community' initiative introduced in England in 1983, may be useful in stimulating joint activity but this particular initiative is only available in connection with hospital discharges in order to ensure that appropriate community facilities are in place. A problem with the initiative is that it encourages field authorities to focus upon emptying beds instead of on preventing new admissions. According to Wistow (1987), resources appear to have been retained within the health service, albeit within small scale institutions rather than hospitals. There is a reluctance to transfer resources to local authorities since they are not trusted to provide appropriate services. As Wistow (1987:90) concludes, 'the lesson of joint finance, which has apparently been confirmed by its successor, Care in the Community, is a need to establish a pattern of incentives which encourages both parties to enter into a symmetrical exchange relationship. Opportunities need to be created for each side to secure their objectives'. At present, such a situation appears far from being the case. Although there are good examples of collaborative activity having taken place on a basis of mutual trust and willingness to work together, many of them cited in the previous section, the joint planning field is littered with the wreckage of numerous attempts to overcome mutual suspicions among practitioners

and managers which can all too frequently be a feature of attempts to collaborate.

5.5 Professional Considerations

5.5.1 The importance of professional considerations in the achievement of joint planning cannot be underestimated. Professional defensiveness served to thwart numerous attempts at collaboration. As Challis and others (1988:215) point out, notions of status are important barriers. 'The high-skill, high-tech arena of health professionals, and the clear articulation of a health service administration was contrasted with the undifferentiated and "amateurish" efforts of social services'.

5.5.2 Whereas much of the concern about joint planning centres on structures, on creating coterminosity, and on achieving the planned organisation of service boundaries so as to minimise multiple overlaps, in reality the need for various professionals and managers to negotiate their way around obstacles and do deals was of greater consequence if not fully accepted or understood. Consensus resulting from the assessment and negotiation of mutual benefits 'is an achieved and constructed quality, rather than an automatic precursor of thinking about coordination' (Challis and others, 1988:266).

5.5.3 It is also the case that inter-professional working poses different problems at different levels of organisation. In practice, frontline workers do coordinate their work on a day-to-day basis with considerable success. This activity is commonly centred on specific

cases. Moreover, there are moves, as reported earlier, to establish key worker roles to coordinate such activity more effectively. The major problems over inter-professional and inter-authority cooperation occur at more strategic planning levels where there is an absence of a strategy or vision about the direction in which services for particular care groups involving the interests of many services and agencies should move.

5.5.4 The Audit Commission (1986:70) pointed to the importance of 'committed local "champions" of change'. It maintained that 'probably the single most important factor common to all the successful community care initiatives observed during the study was the presence of people with a vision, determination and stamina who had pushed developments along.' The Commission went on to argue that where mutual trust existed between senior officers from health authorities and SSDs, the relationship appeared to be far more important than joint planning machinery. However, it was noted that joint planning machinery tended to work better under strong direction.

5.6 Guidelines for Policy

5.6.1 It is potentially misleading to distil complex processes into simple operating rules. Nevertheless, at the risk of gross oversimplification, it is possible to derive from the evidence presented in the foregoing sections a set of guidelines which appear to be important in accounting for successful attempts at joint planning. In most cases it is not possible to legislate for such

factors in order to ensure that they exist within the joint planning arena. Nevertheless, awareness of their importance is a first major step in ensuring that they are attended to.

5.6.2 Before embarking on this exercise it is salutary to acknowledge how misleading the easy rhetoric of joint planning can be. Friend (1981) has identified a number of dangers associated with the underlying assumptions which the adjective 'joint' can suggest. The assumptions have much in common with the idealistic approach described in Section 2. They may be summarised as follows:

Assumptions of Equality in Status among two or more partners can raise difficulties where there are perceived disparities of resources or structure between them - disparities which may well be differently perceived from different vantage points, and may make the interpretation of the principle of jointness difficult in practice not least when it comes to choices about leadership, drafting or administrative roles.

Assumptions of Completeness in representation of all relevant interests; this can involve broadening the membership of a joint structure to include more and more disparity in the forms of the organisations involved and their stakes in the joint planning agenda, aggravating further the difficulties surrounding the notion of equality.

Assumptions of Commitment. The degree of real commitment to shared purpose which an authority can vest in any joint structure must be limited by the breadth of its accountability to other competing interests. The simple rhetoric of 'full commitment' can obscure this reality. Moreover, commitment can change over time as circumstances and personalities change.

Assumptions of Solidarity in reporting by members of the joint body can be dangerous where they encourage an expectation that all its members will stand and fall by a package of recommendations to which they are committed - despite any parallel allegiances that individuals may have outside this particular group.

Friend believes that there may be a wider range of options for the design of structures for joint planning than these assumptions imply but that a well-informed approach is essential if such subtleties about the nature of how organisations function in practice are to be appreciated.

5.6.3 Derived from the foregoing review, the following guidelines for policy are put forward for consideration:

- There needs to be a clear, coherent joint statement of intent or set of principles or strategic vision of what joint planning is aiming to achieve for particular care groups. Otherwise joint planning, and the machinery flowing from it, can all too easily become an end in itself.

- Clear objectives stated in advance are less important than a proven capacity to adopt objectives over time as seems necessary.

- Joint planning takes time and requires leadership, commitment and direction from senior management to ensure that it is given sufficient priority within the organisation and to enable decisions to be taken promptly without constant referral up the line to parent authorities. Particularly in respect of SSDs, considerable delegated authority to representatives on joint planning teams is an essential prerequisite.

- There exists no policy chain in which policies are transmitted from the top of the organisation down to the front line. Policies promulgated at higher levels giving priority to particular care groups are often vague, ambivalent and not particularly relevant, or helpful, at an operational level, where they lack specificity and come up against particular and often varying professional views of how things ought to be done. Locality planning and similar devices are an attempt to bridge the gap between strategic planning and operational decision-making. Joint plans will not succeed if those on the receiving end of them feel excluded from their production. Hence the importance of attention being devoted to vertical joint approaches within agencies as well as horizontal ones across them.

- Joint planning machinery is secondary to joint planning processes. There is a place for reticulists, or 'responsible schemers'. Service managers should have confidence in such people and allow them to operate on the margins of, and within, organisations in order to promote collaborative activity. Many successful joint initiatives have proceeded on an opportunistic basis rather than on a rationally planned basis. Attempts to change behaviour through institutional or structural reform will usually fail unless concomitant changes have been effected in the structure of advantage, ie resource and power dependencies among those groups inhabiting organisations seeking to work together.

- Incentives are important. For some individuals joint planning and collaborative activity is its own reward. But for many others a lubricant is necessary - perhaps in the form of joint finance or bridging finance - in order to provide an incentive and to make progress.

- It is wise to avoid being over-ambitious. Joint planning seems to work best when discrete, manageable projects or initiatives are undertaken. The aims should be modest in order to secure real progress rather than merely the semblance of change. Unrealistic expectations are likely to lead to a loss of commitment to joint planning. As Rein (1983) argues, coordination has been, and continues to be, oversold.

5.6.4 There is no 'how-to-do-it kit' or manual or cookbook for successful joint planning although the analysis of the Neighbourhood Services Project in Dinnington by Bayley and others (1987) provides a useful model of how to derive practical lessons from innovative projects. As the evidence has shown, joint planning is marked by great diversity and what is relevant and works in one area might be quite inappropriate somewhere else. A 'loose-tight' approach many therefore be necessary - loose in the sense of encouraging and fostering diversity in attempts to coordinate, but tight in the clear commitment at all levels to creating a climate in which joint planning and service coordination are seen as integral to the implementation of policy in respect of community care. Allied to this injunction is the need for modest expectations about what can be achieved through joint planning. In this way although progress may appear less dramatic it will amount to genuine progress as distinct from aspirations of intent or ultimately futile exercises in symbolic policy-making.

5.6.5 The evidence also suggests that a considerable amount of innovative work is in progress at a local level confirming Klein's (1983:163) view that 'the NHS is an ant-heap seething with local initiatives: a setting for countless spontaneous experiments in the organisation and delivery of health care'. Perhaps to a lesser degree, much the same can be said of social services departments. But, as Booth (1987:16) warns, a great deal of this innovative work is passing unnoticed or without evaluation. 'There is a real danger that important lessons for policy and practice will be missed because of

this lack of scrutiny'. If policy-makers and managers at all levels are serious about overcoming the administrative and professional barriers which serve to inhibit joint planning and joint working, then there needs to be a commitment to learning the lessons from initiatives which have sought to confront these obstacles. Only in this way can well-informed structures for joint planning be designed which reflect an understanding of the pitfalls, and of how they might best be avoided.

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Appendix 1

LIST OF JOINT PLANNING INITIATIVES

Mentally Handicapped

Scheme	*Reference*
Shift of Responsibility for 355 patients from HAs to SSDs. Somerset.	L. Alleway. 'Bumpy Ride for Handicapped Move'. The Health Service Journal, 12 March 1987, 296-297.
Joint post to manage services run by HA and SSD. Isle of Wight.	Community Living. Joint Post "Will not be Easy" Community Living, Vol 1, No.2, July 1987, 6.
Closure of Darenth Park Hospital and the provision of care for those discharged. Lewisham & North Southwark.	R McCarthy. Lewisham and North Southwark: Putting Care Into the Community. Design for Special Needs 36, Jan-April 1985, 9.
Evaluative studies of the Client Group in 2 Health Districts. Kent.	E. Ferlie, P. Pahl and L. Quine. Professional Collaboration in Services for Mentally Handicapped People. Journal of Social Policy, Vol.13, Part 3 April 1984, 185-202.
Scheme to provide each community in Dorset with its own comprehensive and local service for the mentally handicapped. Dorset.	D. Griffiths and R.L. Browning. Services in Dorset for People with Mental Handicaps. Mental Handicap, Vol.15 No.1 March 1987, 12-15.
A new hostel for the mentally handicapped including 5 houses and 1 flat. Humberside.	H & SSJ. Rural Life for Humberside Handicapped. Health and Social Service Journal. No.4798. May 1982, 653-4. 1982.
Newcastle Mental Handicap Partnership. Newcastle-Upon-Tyne.	L.B. Hunt. Community Services for Community Care. Health Trends, Vol.15, No.4, November 1983, 77-81.
Building a 40 bed hospital. Anonymous AHA covering 3 London boroughs.	F. Marlsen-Wilson. Lessons in Co-Operation. Health and Social Service Journal, June 10 1982, 706-708.
Developing alternatives to residential facilities and community support services. Newark.	Nottinghamshire County Council. April 1987.
Better Organisation of Community Care for the mentally handicapped. West Cumbria.	Nursing Standard. Novel Mental Handicap Scheme. Nursing Standard, 11 June 1987, 6.

Transferring all mentally handicapped into the community. Sheffield.	Rosemary Rogers. 'For Better or for Worse?' Senior Nurse, Vol.3, No.2 July 1985.
Improving and integrating the community care service, between professionals and parents. Newcastle-Upon-Tyne.	B. Roycroft. 'Partners for Priorities'. Health and Social Service Journal. July 14 1983, 84.
A hostel with 12 beds and possible future extension. Kingsbridge, Devon.	O. Sayer. "Strength Lies in Sharing" Patients Voice, Vol 33, No.1, March 1983, 11.
Scheme to move 200 mentally handicapped adults from longstay hospitals. Medway, Kent.	L. Steele. Learning to Make Their Own Decisions. The Health Service Journal, 26 March 1987, 366.
Evaluation of the "Wells Road" service. South Bristol area.	L. Ward. 'A Bit More Peace of Mind?' Social Work Today, Vol.19 No.14, 30 November 1987, 12-14.
Closing 300 bed hospital as a pilot scheme. Cheshire (Merseyside).	R. Waterhouse and J. McLaren. Caring in the Community: A Financial Viewpoint. Public Finance and Accountancy, October 31 1986, 11-12.

Elderly

Setting up a joint care Unit for the very frail elderly who do not need hospital care but cannot live independently. Gainsborough.	S.E. Allard. S.H. Boyd and B. Roberts. Inspection of Collaboration Between Health and Social Services, Lincolnshire. SSI East Midlands Region.
Glaven scheme covering 12 villages of which 30% are pensioners. Rural Norfolk.	A. Allibone and R. Coles. 'There's No Place Like Home'. Nursing Mirror, Vol. 158. No.10, 7 March 1984, 22-23.
Study of community care services for the elderly in 12 different areas. (Kent).	E. Ferlie. Innovation and Stagnation in the Community Care of the Elderly. PSSRU October 1986.
Joint Project Teams set up in small geographical area to evaluate services and initiate new ones. Northamptonshire.	R. Gibbins. Trying Something Out Locally. Community Care, No.517, 17 May 1984, 18-20.
Balance of Care Project for the Elderly. Wiltshire.	Health and Social Service Journal. Patterns of Care for elderly people. The Health and Social Service Journal, July 22 1982, 890-891.

Incorporating a day hospital for the elderly into a sheltered housing scheme. Faringdon, Oxfordshire.	L. B. Hunt. Community Services for Community Care. Health Trends, Vol.15, No.4, November 1983, 77-81.
Community Dementia Scheme. Hinckley, Leicestershire.	A. Hyde. Joint Care Award. Health and Social Service Journal, 4 August 1983, 922-923.
Evaluating and Improving Services for the elderly. London (2 Boroughs).	N. Korman. Funds for Innovation. Health and Social Service Journal, 17 June 1982, 740-742.
Pilot Scheme: Home for 18 elderly who need care but not hospitalisation. North of England.	S. Levison. Community Care - Funding the Public Sector. Architect's Journal, Vol.181, No.20, 15 May 1985, 83-87.
Three way collaboration in a county?	A. H. Lord. The Frail Elderly - a Challenge of Collaboration. Journal of the Royal Society of Health. Vol.103, No.6, December 1983.
Joint funded post in Occupational Therapy to bridge the gap between hospital and community OT's. Wandsworth.	D. Newman. Bridging the Gap - An Evaluation of the Joint Funded Occupational Therapy Approach. British Journal of Occupational Therapy, Vol.50, No.6. June 1987.
A Community Care Scheme utilising local resources and existing schemes. East Kent.	PSSRU. Community care. PSSRU Newsletter, Summer 1983, 5-6.
Change of resources from residential to domicilliary care. Sussex.	M. A. Reynolds. Disjointed Finance. The Health Services, No.58, Supplement. 23 September 1983, i-ii.
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APPENDIX 2

CATEGORIES TO AID ANALYSIS OF JOINT PLANNING MATERIAL

1. Location of Project
2. Client Group
3. Lead Agency
4. Scale of Project
5. Key Participants
6. Source(s) of Funding
7. Brief descriptions of Project
8. Nature of Success
9. Nature of Problems or Failure
10. Other

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