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THE JOINT FINANCE SCHEME IN HAMPSHIRE 1976-1982

by

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ABSTRACT

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The changing pattern of health care in the later twentieth century in England, with a need to care for more elderly people and those with chronic disease or disability, has recently forced increased consideration of how the administratively separate health and social services might collaborate more closely over caring for those who need a combination of health and social care. The 1974 reorganisation of the National Health Service produced a formal system of collaboration through Joint Consultative Committees and Joint Care Planning Teams and in 1976 the joint finance scheme was set up offering a sum of money available jointly to health and social services departments to promote community based schemes.

The objectives of this research were to examine the working of the joint finance scheme in a particular area from 1976 - 1982 and to evaluate the effectiveness of the scheme in promoting collaboration and innovation. To do this it was necessary first to define and operationalise the concepts of collaboration and innovation. The fieldwork consisted of observation of a joint committee of officers of health and social services departments concerned with allocating joint finance, interviews with selected personnel, examination of records, and two case studies of individual joint financed projects.

The study shows that there were both economic and structural factors, and factors in the design of the joint finance scheme itself which limited collaboration. Initial expectations of the scheme were too great. However, it did provide a stimulus to collaboration and to some degree to innovation and was particularly important in offering the opportunity for a small number of key officers to learn to collaborate over a period.

ABBREVIATIONS

ADSS	Assistant Director of Social Services
AHA	Area Health Authority
AH a,b	Successive administrators from the AHA who provided secretarial services to the Joint Finance Executive
AT a,b,c	Successive representatives from the Treasurer's Department of the AHA who attended the Joint Finance Executive
DHA	District Health Authority
DCP	District Community Physician for Southampton Health District
DHSS	Department of Health and Social Security
HDA	Administrator from Portsmouth Health District on Joint Finance Executive
HSLO	Health Services Liaison Officer
JCC	Joint Consultative Committee
JCPT	Joint Care Planning Team
JFE	Joint Finance Executive
LCP	Specialist in Community Medicine (Liaison Social Services)
NAHA	National Association of Health Authorities
NHS	National Health Service
PDA	Project Development Assistant, Social Services Department
RHA	Regional Health Authority

NOTE ON TERMINOLOGY

In this study "joint finance" is used to describe the scheme set up under DHSS circulars HC (76) 18: LAC (76) 6 and HC (77) 10: LAC (77) 10 and projects in Hampshire funded under these regulations.

The term "joint funding" is used to describe arrangements by which health and social services or other authorities contribute jointly out of their normal budgets to a particular project.

CHAPTER I. INTRODUCTION AND METHODOLOGY

The changing pattern of health care, with more emphasis on caring for patients with chronic disease or disability, and a particular concern with the needs of the elderly - in 1971 16% of the population were over retirement age compared with 6% in 1901 (DHSS 1976) - has brought about a greater recognition of the social aspects of care. There followed the realisation that the separately constituted health and personal social services needed to improve collaboration in the provision of care for many of these patients. The 1974 reorganisation of the National Health Service provided for a formal system of collaboration through Joint Consultative Committees (JCC) and Joint Care Planning Teams (JCPT). In 1976 the joint financial scheme was set up, offering a source of finance within the Area Health Authority (AHA) Budget specifically for projects of interest to both health and social services departments which would promote community based services.

The objectives of the present research project were to examine the working of the joint finance scheme in the area served jointly by Hampshire County Council and Hampshire Area Health Authority from 1976 until the reorganisation of the National Health Service in April 1982, and to evaluate the effectiveness of joint finance in promoting an increase in collaboration between health and social services authorities. An additional objective was to examine whether joint finance aided innovatory ways of working. The joint finance scheme makes it possible for ideas to be put forward from a variety of sources, and the study considers where ideas were generated and how they were processed, rejected or accepted and implemented. A further area of interest was the relationships between the key actors within the various bodies concerned with joint financing, both statutory and voluntary, and the effects of these relationships on the operation of the scheme.

Some Recent Studies of Collaboration

Other research workers have investigated both collaboration in general and the joint finance scheme in particular and this research project both builds on and extends previous studies. Since the introduction of the joint finance scheme in 1976 there have been four main studies of collaboration between health and social services authorities which include some consideration of the scheme.

Lauerman's Study

Lauerman studied joint finance projects in four shire counties in 1977 (Lauerman 1980). Initially he had hoped to consider a four year period, but the complexity of the machinery for approving projects forced him to limit his enquiries to one year only. He was interested in examining whether joint finance schemes did reflect the "total care" and "common interest" spoken of in the DHSS circular HC(77)17: LAC(77)10 which provided the basis for the operation of the scheme. He suspected that the National Health Service (NHS) wished to "slough off" the less glamorous forms of care, such as that for the elderly and handicapped and that the Department of Health and Social Security (DHSS) might be using joint finance to exert some control over local authority spending. Both these concerns reflected his local authority background. Lauerman concluded as a result of his study that the joint finance scheme had been operated in a variety of ways in the counties he studied but that monies did not, in the main, appear to have been spent on schemes aimed at achieving "total care" or satisfying "common (client) interests" of the health and local authorities in 1977/8. He criticised both the concept of joint finance, describing it as ill-conceived and simplistic to some degree, and also poor local administrative arrangements and lack of vision. He asserted that joint planning and financing "assume a congruity of interest in total care which is health biased and assumed to be shared by the local authority" (Lauerman 1980). His recipe for improving the "efficacy" of the concept of joint finance was more joint training and movement of staff between authorities; more emphasis on co-terminous boundaries; greater use of the organisational approach recommended by the research unit at Brunel University, which relies on stratagems such as creating liaison posts and outposting staff from one service to another (Jacques 1978).

Booth's Study of Calderdale

A second study of collaboration between health and social services was that undertaken by Booth in the single district AHA of Calderdale covering the period 1974 to 1979 (Booth 1981a). This AHA had co-terminous boundaries with the local authority. The general aim of his study was to discover how far the objective of collaboration was realistic in view of the difference between health and social services - political,

organisational, financial and professional. (These differences will be analysed in Chapter III of this study). His assumption was that these differences were crucial, and he wished to examine their effect. He investigated how these differences showed in daily working and affected joint planning, and how they produced different perceptions about the value and purpose of collaboration. He looked too at the role of the JCC and the value of cross-membership of the AHA.

Booth found that, although there had been improvements in joint planning and operation, especially after 1976, officers and members of each service doubted whether a full planning partnership was possible. They felt the differences in aims, perspectives, funding structure and local priorities were too great. Joint finance had provided most of the impetus for the improvement in collaboration, although it had deflected attention from strategic planning and had not been used for innovation at all. The JCC had been ineffective, but one reason for this was that factors outside the control of local health and social services authorities, such as shortage of resources and manpower limitations, were often responsible for any failure to pursue collaborative policies.

Booth concluded that the commitment of officers and members to collaboration was necessary but not sufficient to ensure its success. Other projects within each service competed for resources, and national factors could vitally affect possibilities for collaboration. Each service might have similar goals for a particular care group but the means of reaching these goals might be pursued in different ways. Inducements, either rewards or sanctions, might be necessary to overcome barriers to collaboration. Without major reforms in the structure and organisation of both authorities Booth felt that collaboration was unlikely to improve.

The Loughborough Research

A third study of collaboration was that financed by the Nuffield Foundation at the University of Loughborough from 1979 to 1981 under Professor Adrian Webb to look at joint planning and joint financing. The final report has not been published at the time of writing but indications of the findings have appeared in a number of different publications from the University of Loughborough, and in various journals.

The research project was conceived with a number of key issues - the relationship between joint planning and joint finance and whether the latter has promoted the development of the former or indeed other types of collaborative working; the development of procedures and processes of joint financing; the respective roles of officers and members; the financial implications of joint financing and the extent to which it has contributed to the achievement of national and local priorities; and finally the implications of expenditure restraint. The area of study was the Trent Regional Health Authority and the AHAS and local authorities which lay within its boundaries.

Overall the project found that their respondents reported "greatly superior (collaborative relationships) at policy and planning levels to those pertaining before re-organisation". (Wistow and Webb 1980). Co-terminous boundaries were thought to have been helpful in this. However, a number of problem areas still existed. Webb and Wistow found a lack of consensus over objectives for collaboration and a concentration on operational issues and joint finance, to the exclusion of broader aspects of collaboration. The complexity of the collaborative structures particularly in multi-district areas, the division of functions between County and District Councils and the lack of formal policy and operational links between local authorities and health districts created confusion.

The main research was amplified by a survey of AHAs who were members of the National Association of Health Authorities (NAHA) carried out for the Association by Wistow and Head in April 1981. This survey was particularly concerned with opinion about the joint finance scheme and its future (Wistow and Head 1981). Evidence from this survey and the main research showed a preference for capital rather than revenue schemes, because of a reluctance to take on revenue commitments and the effect of manpower restrictions.

Joint funding (as defined in the note on terminology) was seen as one way of overcoming operational difficulties in the future. The Loughborough research demonstrates that

> "the barriers to co-operation in the health and personal social services are multi-faceted. Legal, administrative, financial and attitudinal barriers all play a part.... The mix is a complex and changing one. It is by no means clear that the nature of its individual ingredients have been fully identified and taken into account at either central or local levels of administration" (Wistow 1981).

Norton and Rogers Study

Norton and Rogers were particularly interested in collaborative innovation. In 1977 they wrote to AHAs and Social Services Departments in five Health regions (Merseyside, Trent, Wessex, West Midlands and Yorkshire) asking them to give details of innovations in services for the elderly that had been dependent on inter-authority collaboration. Innovation they defined as a new concept or new form of collaborative working. Of the 168 projects reported to them they regarded 77 as innovative on their definition and of these 49 were joint financed. They then investigated eleven projects in depth, of which four were joint financed. (Norton and Rogers 1981).

They concluded that the model of rational strategic planning proposed by the DHSS for joint planning is inappropriate. The objective analysis of need by either service is undeveloped and resource allocation is dominated by the need to maintain existing services particularly in a time of resource restraint. Therefore the problems of collaboration become more acute. Innovations, they suggested, did not arise from high level joint machinery which was best suited for stock types of unit but arose from an individual's response to a particular problem. For this reason they prefer a "bottom-up" to a "top-down" model of innovation, in which implementors are involved in planning, to provide for small scale change. They confirmed the difficulties in the way of collaboration described in the other studies - the different objectives of health and social services personnel, the complexity of the collaborative structures and the effect of shortage of resources.

The Place of this Study

The other studies of collaboration described above have been on a relatively broad scale with little detailed discussion of the operation of the joint finance scheme. Booth's study of Calderdale is the most detailed study of one area. The joint finance scheme is a new venture in social policy and there seemed to be a place for careful exploration of its operation over time in a defined area. Glennerster in his book "Social Services Budgets and Social Policy" sees a practical need for such an approach.

> "Services are not dismantled and rebuilt every year, although currently workers in the field may be forgiven if they have that impression. Programme managers also need detailed and highly specific studies by people thoroughly conversant with the statutory framework, regulations and problems that officials face. These are approaches that the pressures of academic life do not normally encourage" (Glennerster 1975).

Wistow (1981) in the passage already quoted suggests that

> "it is by no means clear that the nature of the individual ingredients (of the barriers to co-ordination) have been fully identified and taken into account".

It was to provide such a detailed examination which might further elucidate the operation of the joint finance scheme that this study was undertaken. Since the particular focus of the study was to evaluate the effectiveness of the scheme in promoting an increase in collaboration and to examine whether the scheme aided innovatory ways of working, a necessary first step was to clarify and operationalise, in the context of health and social services, the concepts of collaboration and innovation. Once this was done a descriptive analysis could be undertaken of the joint finance scheme in Hampshire from its introduction in mid-1976 until the health services reorganisation of 1982.

Methodology of the Fieldwork

The area studied was that covered jointly by the administrative county of Hampshire and the Hampshire Area Health Authority from mid-1976 to April 1982. It excluded those parts of the administrative county which formed part of other Health Authorities. In the west the area round Fordingbridge was the responsibility of the Wiltshire AHA although still within the Wessex Region. In the north-east the North East Hampshire/South West Surrey Health District was part of Surrey AHA in the South West Thames Region. (See map Appendix I). These "overlap" areas look to their respective AHAs for their joint finance money, although a representative from Hampshire County Council, the Health Services Liaison Officer, attended their Joint Care Planning Teams until December 1981. Similarly, a representative from Surrey, often a Community Physician, would attend the Hampshire JCPT. Within the area of study there were four Health Districts - Basingstoke and North East Hampshire, Winchester and Central Hampshire, Southampton and

South West Hampshire and Portsmouth and South East Hampshire. The Social Services Department of the County Council was sub-divided into the South West Division, covering most, but not all, of the Southampton Health District, the South East Division covering largely the Portsmouth Health District and the Northern Division covering Basingstoke Health District, Winchester Health District and a small part of Southampton Health District. Within the area of study there are also thirteen District Councils. Hampshire had to create a collaborative structure in which all these bodies and the various voluntary organisations could play their part.

In considering the methods of investigation it seemed useful to accept the view of Selltiz et al (1965) that in exploratory studies

> "a major emphasis is a discovery of ideas and insights. Therefore, the research design must be flexible enough to permit the consideration of many different aspects of a phenomenon".

They recommend an experience survey, that is interviewing individuals who have experience of working in the field studied, and the analysis of "insight - stimulating examples" or case studies, as fruitful methods. Booth (1981a) lends support to this view. In the discussion of the methodology for his Calderdale study he suggests that the case study is best for looking at social processes which are difficult to measure numerically as it allows for the actor's own perceptions and lends itself to more intensive and open-ended investigation, especially useful in a new field. Quantitative methods would have been difficult to use. The complexity of the administration of the joint finance scheme forced Lauerman to limit his own study to one year, rather than four years as he originally hoped. (Lauerman 1980). Earlier in this chapter the long list of organisations which could be involved in the collaborative process in Hampshire was given. An indefinite number of officials in these organisations could be drawn into negotiations over joint finance allocations. A descriptive analysis of the scheme was more appropriate at this stage of knowledge. In order to obtain material for this, four main methods were used:- observation, semi-structured interviews with key personnel, record search and case studies.

a) Observation

In examining the operation of the joint finance scheme it was important to look at the process by which ideas for the projects were generated and how they were processed, sorted, rejected or accepted and implemented. The committee through which all applications for joint finance money had to pass in Hampshire was the Joint Finance Executive (JFE), a sub-group of the Joint Care Planning Team (JCPT). The JFE had members drawn from the officers of the AHA, the Social Services Departments, the District Councils, the Health Districts and the County Council Treasurer's Department. The operation of this Committee will be fully discussed in Chapter Six. Both collectively and through its individual members, the Committee provided advice to those applying for joint finance, sorted applications and recommended their acceptance or rejection to its parent body, the JCPT. The JCPT could, and occasionally did, overrule its recommendations.

The author was permitted to attend all fifteen sessions of the JFE which took place from June 1980 to March 1982 as an observer. She was supplied with all the papers relating to the sessions which she attended. The members received her in a friendly and courteous manner and discussion seemed to flow freely, despite the presence of an observer. The only discussions she was not able to observe during the sessions were those occurring between individual members during the brief coffee break, when members collected cups of coffee from a machine. It does seem likely, however, that the author's presence did introduce some element of distortion into what was, from June 1980 until September 1981 when the JFE expanded in membership in anticipation of NHS reorganisation, a relatively small and stable group - normally eight or nine people. It was not possible to determine how great that distortion might be. The author had conceived that her role would be that of a non-participant observer but it quickly became apparent, as Stacey (1969) observes, that there is no firm line between participant and non-participant observation, particularly in such a small group. Moreover, the author was an employee of one of the authorities represented at the JFE, the Social Services Department, and one of the officers, the HSLO, was the Head of the Section in which the author was employed. However, the author had not previously met, as an employee, any of the officers of the Social Services Department whom she encountered

in the course of the observation. Gans (1965) observes in his comments on the role of the participant-observer "The participant-observer wants to be liked, and, in his own marginal way, to feel part of the group", and this is true for the role of non-participant observer in so small a group as the JFE. At one meeting the author was asked for her views on a particular topic. As a reorganisation of the Social Services Department was mooted and proceeded in the summer and autumn of 1981, one member of the group who felt particularly threatened by that reorganisation, which was being masterminded by another member of the JFE, sought to draw support from the author at the meetings of the JFE. These factors certainly created problems in maintaining the appearance and the reality of non-participation. Some comfort may be drawn from Deutsch (1949) who found that members of small groups were much more aware of an observer's presence at the beginning of a period of observation than after three meetings.

In addition to the JFE sessions the author attended one session of the JCPT, a closed committee like the JFE, to observe how recommendations from the JFE might be handled. Here again it was difficult to determine what bias might be introduced by the presence of an observer. The author was known to some members of the JCPT from her contact with the JFE and from individual interviews. However, she was not formally introduced at the JCPT by the Chairman, so members not already known to the author would not be aware of her role. Strangers did from time to time attend the JCPT as new staff would on occasion be brought along by officers of either Authority as part of their induction, as they were to the JFE.

From the JCPT recommendations about joint finance applications pass in due course to the Area Health Authority, the Social Services Committee and the JCC. All these bodies hold open sessions and the author's presence at these would have had the same effect as any other member of the public who might attend. It was impossible to determine what that effect might be, but it is a normal part of the working of these Committees. The author attended every meeting of the JCC held in the period October 1979 to April 1982. In fact, the JCC did not meet between December 1978 and May 1980 and then met twice more in 1980 and twice in 1981. (See Appendix II). The functioning of the JCC in Hampshire in relation to joint finance will be discussed in Chapter IV.

The author attended selected meetings of the Social Services Committee when it seemed likely that joint finance would become a focus of discussion. This occurred particularly in the summer of 1980 when cuts in the Social Services budget were being discussed and joint finance was being considered as a means to make up the loss. This will be described in Chapter VI.

b) The Semi-Structured Interviews

It quickly became apparent from attendance at the JFE that there were a relatively small number of officers in the organisations concerned with joint finance who were of key importance, although a larger number might well be involved in joint finance applications. Some, but not all, of these key actors were members of the JFE such as the Specialist in Community Medicine (Social Services Liaison) and the Assistant Director of Social Services with the Project Development Assistant working to him responsible for joint finance administration within the Social Services Department. Others, like the able and energetic District Community Physician for Southampton Health District, were very influential in the JCPT. He did not become a member of the JCPT until September 1981. In that month the JFE expanded to include a representative from each Health District in anticipation of Health Service reorganisation in April 1982 when each of the four main Health Districts in Hampshire were to become independent District Health Authorities. All members of the JFE until September 1981 were interviewed, as they were the officers most closely concerned with the administration of the allocation. Other administrators in Health Districts were chosen because they seemed to use the scheme particularly often, as did Southampton Health District, or particularly ineptly as did Basingstoke Health District. This was a by-word in the JFE for its failure to consult adequately with local Social Services officers and for its promotion of projects which did not meet the criteria of the scheme.

Within the County Council the other departments most involved with joint finance, apart from Social Services, were the Treasurer's Department and the Corporate Planning Department. One of the Principal Assistants in the latter had, as a specific part of his job description, to:-

"1. Further the Unit's responsibilities 'for promoting the development of joint planning'.

2. Organise and co-ordinate County Council responses to the reorganisation of the Health Service and to Health Authority strategic, annual and other plans.

3. Provide the secretariat to various corporate officer groups in the field of joint planning and finance".

(Hampshire County Council 1981).

In addition to officers of the health and local government services, it seemed important to sample opinion of the joint finance scheme among AHA and Social Services Committee members. It was clear from comments made in the JCC and Social Services Committee that only a small minority of members understood the scheme, and those interviewed were selected from these. It is of course possible that the misconceptions of ill-informed members might have either facilitated or prevented the use of joint finance, but in view of the complexity of the scheme it proved impossible to devise a way in which this could be adequately tested. This lack of knowledge among members of authorities about the working of the joint finance scheme may spring from the same source as that suggested by Booth in his study of Calderdale (1981a). Officers were able there to exercise more control if there was less scrutiny by members and they controlled the agenda for meetings. It required a persistent and knowledgeable member to overcome this. Three members of the Social Services Committee were interviewed, one each from the major political parties, and the Chairman of the Committee. One member of the AHA was interviewed. The Chairman of the Social Services Committee was also an AHA member and had interesting comments on the contrast of the two roles. All these members were also active on the JCC.

A large number of voluntary organisations in Hampshire have applied and could apply for joint finance. The Secretary of the Hampshire Council for Community Service was selected as a representative of these. In addition, the author's own participation in a voluntary group, Winchester Bereavement Support, and its application for joint finance to launch its activities, provided personal experience of joint finance and voluntary organisations.

A full list of those interviewed appears in Appendix III.

The interviews took place, with one exception, in the offices of those interviewed. The Chairman of the Social Services Committee was interviewed at home at his request. The interviews were semi-structured. An attempt was made at each interview to cover the main areas of the research - innovation, relationships between actors, key relationships and whether collaboration might lead to full integration of health and social services. Because of the different perspectives and different practical experience of the scheme of each individual interviewed, the data obtained was not always strictly comparable. Much of the interview was necessarily concerned with obtaining that individual's opinion of the working of the scheme but this was an important complement to the information obtained from observation at meetings and examination of records. The method of selecting individuals for interview was on the basis of identifying key agencies and key actors within these agencies and it seems unlikely that over the three-year period in which the research was carried out an important key actor could have been overlooked or remained unidentified.

c) Records

The author had access to all official papers for the sessions of the JFE, JCPT, Social Services Committee and JCC that she attended. In addition, she was allowed to examine the files belonging to the Assistant Director of Social Services containing papers from JCPT and JFE meetings of the period March 1978 to May 1979, and other internal departmental papers relating to those meetings. These files were not a complete record. The most complete record was held by the Project Development Assistant in the Social Services Department and he met all requests for information from that record that the author made. The Social Services records did have a Social Services bias as regards informal memos and comments scribbled on official papers, but the official papers were common to both authorities. This bias may have distorted some information but it could be off-set by observation and interviews with officers from the health side. The Service Planner in Southampton Health District supplied the author with copies of correspondence between the District Administrator, the M.P. for Eastleigh and the then Minister of Health, Dr. Gerard Vaughan, over the period April to September 1980 concerning the joint finance scheme. This provided valuable insight into the views of that particular Health District and

into central government attitudes to the scheme. The author also examined the agenda papers and minutes of the Hampshire Area Health Authority from 1976 to 1982.

d) Case Studies

The purpose of looking at two joint financed projects in detail was to examine the scheme at operational level and, in particular, to attempt to determine whether joint finance did promote innovatory working. It was a common expectation that it did so - this point will be elaborated further in the section in the concluding chapter on expectations of the scheme. The two projects were not chosen as "typical" - indeed, it would be difficult to define such a project in Hampshire as the flexibility of the scheme permits of so many variations. The projects selected were one from the field of the elderly and one from the field of joint training. The elderly are one of the biggest consumers of joint finance in Hampshire, second only to the mentally handicapped. By 31st March 1981 £1,007,061 had been spent on Schemes for the elderly out of a total of £4,343,934 joint finance available since 1976. The care they require is par excellence a mixture of medical and social. Training for personnel in the health and personal social services was very compartmentalised until the middle of the 1970s and joint training is still in its infancy. 2½% per annum, that is £17,500 of the joint finance budget in Hampshire for 1978/9, was set aside in February 1978 for joint training schemes, later reduced to £15,000 per annum. Projects in these two areas of the elderly and joint training might demonstrate advantages and disadvantages of joint finance and the problems of collaboration and innovation.

(i) The Housing Assistant (Elderly Persons) Scheme

This project is a collaborative venture between the City of Southampton Housing Department, the Southampton Council of Community Service and Hampshire Social Services Department, involving particularly the Area Social Services Offices of Shirley and Woolston. There will be full discussion of the project in Chapter V. The methods used in the research were semi-structured interview and examination of records. Initially, the Assistant Director of Social Services, who was influential in setting up the project, was interviewed and then three members of the Steering Group responsible for managing the scheme. These were

the Section Head of the Management Section in the Housing Department, the Organising Secretary of Southampton Council of Community Service and the Deputy Principal Area Officer in Shirley Area Office. In these interviews the areas covered were:- Who initiated the project, its purpose, the process of setting it up, had it met expectations, and the effect on inter-departmental co-operation. The same caveats apply to these interviews as to those in the main body of the research - they were not strictly comparable. However, they did assist in building up a picture of the functioning of the scheme. The Housing Assistant attached to Shirley Area Office was also interviewed to obtain information about the day-to-day operation and her view of the scheme. It was not possible to interview the other Housing Assistant as she was ill and then promoted to another post in the Housing Department. The author was permitted to examine the file from Shirley Area Office with minutes of the Steering Committee and letters and memos relating to the Scheme.

(ii) Living Working and Dying Course

This course was devised by a steering committee of representatives from both health and social services to meet a need expressed by personnel of both services for help in working with the dying and their families. The Steering Committee consisted of the Principal and Assistant Principal Officers (Health) for the South West Division of the Social Services Department, a social worker working in the Radiotherapy and Oncology Departments, the Training Officer for the South West Division, the Consultant in Continuing Care from the Southampton Continuing Care Unit, a senior sister from the Oncology Ward at the Royal South Hants Hospital and the Administrator and Information Officer from the Wessex Cancer Organisation. There will be a full discussion of the course in Chapter V. The course took place from January to April 1980.

The methods of research used were semi-structured interview, participant observation and examination of records. Interviews were conducted with all members of the Steering Committee except the Senior Sister and the Information Officer who had left the district. The areas covered in the interviews were:- How did that individual first become involved in the project, what was its purpose and did that purpose change over time, did health and social services have the same purpose, was the course innovatory, was it "successful" and had it prompted more joint courses, and finally what significance did the existence of the joint

finance scheme have for the course.

The author participated in this course by attending the lectures, acting as one of a panel of speakers at one lecture session, and leading one of the discussion groups which met following the individual lectures. As a group leader she met regularly with members of the Steering Committee after the course had begun for discussion of its progress and she had available to her written reports made by other group leaders and an assessment of the course by the Principal Officer (Health) for the South West Division of the Social Services Department.

This participation enabled the author to obtain more immediate data about the effect of the course on those taking part and allowed her to make a more informed assessment of whether the objectives of the course and the joint finance scheme were met. However, it inevitably introduced an element of bias. It can be speculated that that bias might have the effect of producing a more favourable assessment of the course than might have been made by a non-participant.

Summary

This chapter has introduced the purpose and focus of this study and set it in the context of recent work on collaboration and innovation. It has described the geographical area studied, the organisations involved in collaboration within it, the reasons for choosing the method of descriptive analysis and the four main methods used to provide that analysis. The ways in which those four methods were applied have been discussed and any particular difficulties associated with that application. Before embarking on the research proper - that is, the clarification and operationalisation of the concepts of collaboration and innovation, and a discussion of the fieldwork - it is important to set existing health and social services and collaborative structures in a historical context.

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CHAPTER II. THE HISTORICAL BACKGROUND OF THE HEALTH AND WELFARE SERVICES

The most efficient and most humane way of organising health and welfare services is a perennial focus of discussion in Britain. The balancing of economic, political, administrative, historical and social factors, in different ways at different times, has produced different organisational forms, each with its advantages and disadvantages.

Contemporary health and welfare services show the marks of these changes and it is therefore important for any study of current relationships between these services to put them in their historical context.

The Nineteenth Century

Although forms of social provision existed before, the 1834 Poor Law Amendment Act is usually regarded as the beginning of a modern approach to social problems in Britain. The major problem of the period was seen as able-bodied pauperism. There was widespread dissatisfaction with the Speenhamland system which had evolved on the basis of the Elizabethan Poor Law. This involved the payment of relief from the parish to the poor in their own homes and, particularly in Southern England, had often been used to subsidise agricultural wages. It had been criticised by Malthus as encouraging large families and by liberal political economists and the new industrial entrepreneurs as impeding mobility of labour (Briggs 1959). The Act of 1834 proposed that relief should only be administered in workhouses set up by each parish which were to be supervised by a national inspectorate. Conditions in the workhouses were to be so spartan as to make the inhabitants less well off than the poorest labourers - the principle of less eligibility. Paupers would be disenfranchised. (This was relatively unimportant in 1834 as few who turned to the parish had the vote, but it became more significant as the franchise widened later in the nineteenth century). The aim was to make the workhouse so unattractive that the inhabitants would be forced to re-enter the labour market. The principles underlying the Act sprang from the political economy of laissez-faire and the conviction that work was always available to those who really sought it. Moreover, idleness was seen not only as a sin but as a danger to society because of the possible revolutionary propensities of a large

body of those with no interest in maintaining the current social order. Many of these attitudes are apparent in contemporary debates about social problems. As Pinker (1971) observes, the 1834 Act had positive economic and negative welfare functions.

Out-relief did continue unlawfully in some areas, partly because of the problems of large scale unemployment in the new industrial towns caused by economic fluctuations, partly because some parishes were reluctant to undertake the expense of erecting and staffing a workhouse. However, in the main the workhouse became the major institution succouring those in need. Initially there was no differentiation of the causes of an individual pauper being in want. However, as the century progressed the problem of the sick poor forced itself more and more on the attention of the Poor Law Commissioners and the public. Those in want through sickness always formed a large proportion of workhouse inmates. In 1861 it was estimated that 50,000 out of a total of 130,000 were sick or infirm. There were only 11,000 voluntary hospital beds in England and Wales and these were closed to paupers by those who controlled them, partly because a pauper would not be able to meet the cost of his own funeral, partly on moral grounds - paupers were classed as undeserving. Moreover, as medical science developed, following on the public health improvements pursued by sanitary reformers like Chadwick, doctors began to assume control of admissions to voluntary hospitals and preferred to exclude those with infectious or chronic diseases. (Abel-Smith 1964).

In the 1850's and 1860's there were a number of sick ward scandals concerning the treatment or lack of treatment of sick paupers and in 1865 the medical periodical "The Lancet" published an investigation into workhouse conditions. It was becoming clear that it was impossible to provide within the same institution a regime which was both deterrent to the able-bodied and therapeutic to the sick. The Poor Law Board and the local Boards of Guardians were more concerned to make the workhouse regime more deterrent and to stop out-relief where it still persisted, in an effort to reduce local rates.

The Metropolitan Poor Act of 1867 was one result of these concerns. Boards of Guardians in London were empowered to combine to establish separate fever and general hospitals to be funded from a common poor fund. Local Boards failing to build separate hospitals or establish

dispensaries offering some medical services to those living at home could not draw on the fund to pay the salaries of their medical officers. By the end of the century the Metropolitan Asylums Board responsible for public hospitals in London "had developed into one of the largest and most effective hospital systems in the world". (Abel Smith 1964). In 1869 the Poor Law Amendment Act extended these powers to Boards in the provinces, although without the establishment of a Common Poor Fund. The new hospitals were still operated under the Poor Law but they were increasingly used by those in employment. The 1871 census showed that 82% in Hampstead Hospital were gainfully employed, usually as skilled artisans. There were still too few voluntary hospital beds and doctors' fees were too high for the artisan and labourer. By 1885 there was official recognition that those in Poor Law Hospitals and those in the workhouse posed different problems in the shape of an Act, the Medical Relief Disqualification Removal Act 1885, which saved the sick pauper from disenfranchisement.

The removal of the sick pauper gave the Poor Law Board the opportunity to set up a more deterrent system for those who remained. The House of Industry set up by the Poplar Board of Guardians in 1871 offered a harsh regime with a work schedule harder than that for prisoners in contemporary gaols. But this and other similar experiments failed. There was a humanitarian outcry but economics lay at the heart of the failure. Unemployment forced people into the workhouse regardless of conditions, but they would try by all means to leave those with the harshest regimes. Successful deterrence left the workhouse empty but the Board of Guardians still had to meet the cost of providing it and this was hard for local ratepayers to accept.

1900 - 1948

By 1905, when a Royal Commission was appointed to enquire into the Poor Law, there was again dissatisfaction with the existing systems of health and welfare. In their evidence to the Royal Commission, the Poor Law Board proposed that the sick should be entirely removed from the Poor Law so that there could be a return to the principles of 1834. In the end the Majority Report of the Commission in 1909 proposed only a few minor changes, whereas the Minority Report produced by Beatrice Webb, Francis Chandler and George Lansbury, proposed the

complete break-up of the Poor Law System. The Government did not act on either report but instead put forward legislation which both by-passed and supplemented Poor Law provision. The 1911 National Insurance Act set up a state insurance system for working men (but not their families) earning under £160 per annum, which soon overtook the existing voluntary system of provident clubs and friendly societies. This provided for financial assistance and free primary health care for contributors in sickness. Non-contributory Old Age Pensions had already been introduced in 1908.

The social policy legislation of the 1906-1911 Liberal Administration demonstrated the change in values since 1834. The collectivist ideals, put into practice by pragmatists like the Webbs, building on the "blue book" sociologists of the nineteenth century and the surveys of Booth and Rowntree, were challenging the values of the free market, beloved of the supporters of 1834. Nevertheless, although ideals of social justice were important, they did not displace other concerns. The anxiety about "the condition of England" was linked to the recognition of Germany's increased industrial and military power, and of the part that Bismarck's social legislation had played in this. As industrial processes became more complex a skilled workman became more valuable to his employer and it became worthwhile to invest in a system which would restore him to active work more quickly.

The welfare services and the public hospitals and clinics continued to be administered by the Poor Law Board until 1929 and on its abolition by local authorities. The voluntary hospitals and general practitioners continued to operate outside these systems. General practice had been greatly stimulated by the 1911 Insurance Act and there was continued pressure from the doctors, based partly on humanitarian grounds, partly on improvements in medical care and partly on grounds of professional advantage, to bring all citizens within the scope of the scheme. The Dawson Report in 1920 had proposed the provision of an integrated health service and the 1926 Royal Commission on National Health one funded from taxation, but these proposals foundered on the twin rocks of B.M.A. opposition and economic crisis (Topliss 1978). The voluntary hospitals found it increasingly difficult to secure an income adequate to maintain and improve their services in competition with the municipal hospitals (Abel Smith 1964).

The Second World War provided the catalyst for organisational change in the administration of the health and welfare services. The threat of war in 1938 evoked memories of the chaos in the hospitals following the influx of casualties from the trenches in the 1914-1918 War and induced the government to set up the Emergency Medical Service, which employed doctors and nurses on a salaried basis and took over control of selected municipal and voluntary hospitals. By 1941 80% of hospital beds were under its control. (Marwick 1968). Treatment was free. The large-scale evacuation of children and their mothers from urban to rural areas opened people's eyes to the inequalities in conditions of living, and the feeling grew that shared sufferings should bring a more just and equal society after the war. The Beveridge Report on Social Insurance and Allied Services published in 1942 paved the way for a flood of white papers on employment, national insurance, health, education, which formed the basis of the reforms of the 1945-50 Labour government.

1948 - 1974

It was in 1948 that the administrative separation of health and welfare services became more marked. The 1946 National Health Service Act set up a tripartite system of administration for health services. This reflected the historical development of those services. Hospital services were under the control of a Minister of Health and paid for out of taxation. Fourteen Regional Hospital Boards controlled nearly four hundred Hospital Management Committees. Teaching hospitals were organised separately under Boards of Governors. For family practitioners, dentists, opticians and pharmacists, Executive Councils were set up in areas corresponding to local authority boundaries which effectively extended and continued the contractual arrangements of the 1911 National Insurance Act. The third strand was services organised by local authorities, including maternity and child welfare, ambulances, Home Helps, Health Visitors, District Nurses, Mental Welfare Officers, Health Centres and preventive health. The School Health Service remained the responsibility of the Ministry of Education.

In 1948 welfare services were divided between a number of local authority departments and under the supervision of various central government ministries. The Children's Department was responsible for the

care of children deprived of a normal home life. The Home Office was the central government department concerned. Welfare Departments, often administered by the same Committee as Health Departments, were largely responsible for the welfare of the elderly, the physically handicapped and the mentally handicapped and for providing residential accommodation for them where appropriate. The Ministry of Health exercised central control. Other local authority departments, such as education and housing, also carried out welfare functions, under the supervision of their respective ministries. The probation service provided a social work service to the Courts, but outside the local authority. With the final break-up of the Poor Law in 1948 income maintenance outside the National Insurance Scheme became the responsibility of the National Assistance Board.

By the beginning of the 1960s the deficiencies of this system of administration had begun to be apparent and pressure for change built up in both the health and welfare services. This was not merely because of administrative or organisational problems, it reflected also the changing patterns of social and health care needs. Programmes of immunisation and treatment with antibiotics following on the public health measures of the Victorians, combined with improved diet, had reduced mortality rates and cut the death rates from tuberculosis, enteric fever and the major infectious diseases of childhood by 99% in the period 1875 - 1975 (DHSS 1976). Although birth rates have decreased, the increase in life expectancy has produced a larger population with a larger and increasing proportion of elderly. The architects of the National Health Service hoped for a reduction in sickness as health services became available to all. Instead, the success of modern medicine has resulted in the elimination or amelioration of much acute illness and substituted chronic degenerative conditions associated with permanent disability and old age. (Topliss 1978). This change in consumers of health services produced, in turn, a growing concern among professionals involved in those services with care rather than cure and a greater recognition of the social aspects of care. Collaboration between the health and welfare services over the elderly, the physically handicapped and the mentally handicapped became a priority. In these groups of clients/patients any individual was likely to have both medical and social needs which one service alone could not meet.

However, each service needed to become more integrated itself before it could collaborate effectively with the other. Webb (1978) identifies the major issues from 1948 to 1973 as unification within each service, the forging of links between the separate services and the growth of the concept of community care and of community services. The personal social services achieved unification first. The fragmentation of social services between the various local authority departments might result in a number of social workers visiting one family at one time, each employed by a different department. There was increasing recognition, following the Beveridge Report, that the cause of many social problems lay in society rather than in the individual, and an increased interest in preventive work exemplified by the Ingleby Report on the Child, the Family and the Young Offender in 1965. Social workers, too, were growing in numbers and becoming more professionalised with improved training. These factors led to the appointment of the Committee on Local Authority and Allied Personal Social Services in 1965 under the chairmanship of Sir Frederick Seebohm. It reported in 1968 that

> "the present structure of the personal social services ignores the nature of much social distress. Because problems are complicated and inter-dependent, co-ordination of the work of Social Services of all kinds is crucial. A unified (Social Services) Department will provide better services because it will ensure a more co-ordinated and comprehensive approach to the problems of individuals and families and the community in which they live". (Cmnd. 3703 Chap. VII).

Its recommendations were implemented in the 1970 Local Authority Social Services Act, which set up social services departments in local authorities, uniting the functions of the former Children's Departments, Welfare Departments and including Education Welfare Officers and those personnel in the Health Departments whose skills were more in social than in medical care, such as Home Helps and Mental Welfare Officers. Hospital Social Workers were outside the Committee's terms of reference and remained in the employ of Hospital Management Committees. The Probation Service, too, remained independent.

Health Services Reorganisation

A number of reports during the later 1950s and 1960s expressed dissatisfaction with the current organisation of the Health Service and

pointed towards some of the changes that occurred in 1974. The Guillebaud Report of 1956 on the cost of the National Health Service did not recommend major change, although Sir John Maude in a note of reservation identified already as weaknesses in the system the tripartite structure and the excessive influence of the hospitals which starved community services of resources. He, like the Dawson Report in 1920, saw the possibility of unification of health services within the local government system if problems of finance could be overcome. The Porritt Committee, an independent group of doctors, in 1962 recommended unification of the service under Area Health Boards and identified another matter of growing concern - the disparity of resources between and within different regions which had not been ameliorated by the creation of a National Health Service. In 1968 the Green Paper published by the Minister of Health, Kenneth Robinson, "The Administrative Structure of Medical and Related Services in England and Wales", was the first stage of the official process ending in the National Health Services Reorganisation Act 1973. This proposed forty to fifty Area Boards unifying health services with boundaries related to local government, possibly administered by the new local authorities suggested in the Report of the Royal Commission on Local Government in 1969. This proposal was too radical to gain widespread support and, in any case, it seemed too difficult to resolve the problem of financing health services from local resources. A further Green Paper published in 1970 by Crossman, Secretary of State for the new Department of Health and Social Security formed in 1968, suggested another structure - that of Regional and Area Authorities responsible to the DHSS independent of local government, but with the boundaries of the new area authorities related to local government boundaries. Public Health and personal Social Services were to remain within local government. A third tier of Health Districts was to be responsible for the operation of services under the Area Authorities.

The change of government in 1970 brought a new Conservative Secretary of State, Sir Keith Joseph. He produced a Consultative Document in 1971 with some changes in emphasis. Although he commented "In a perfect world the answer would be to unify health services within local government" (DHSS 1971), he retained the Region, Area, District structure but strengthened the Regional tier by placing responsibility for planning,

resource allocation and building there. The Area Authorities would take over the hospital services and the services previously administered by local authorities, insofar as they were supplied by individuals with a predominantly medical or nursing skill. The general practitioners continued to be in direct contract with the DHSS but Family Practitioner Committees responsible to the Area Health Authorities replaced the former Executive Councils. Professional Advisory Committees at Region and Area supplied an arena for doctors, dentists, opticians and pharmacists to make their professional voices heard, and Community Health Councils were intended to represent the consumers of health services. In the main, these proposals were embodied in the 1973 National Health Service Reorganisation Act.

Health and Social Services had thus each achieved a greater degree of internal integration. It remained to establish a better framework for collaboration between them if they were to respond to the new needs arising in the consumers of health care discussed earlier in this chapter. Soon after the Consultative Document was published in 1971 two working parties were set up, one to discuss management arrangements for the new service, and one to discuss collaboration between the NHS and local government. The latter working party produced three reports containing recommendations concerning the planning and operation of collaborative arrangements and the provision of services by one authority to another. The government accepted these recommendations and they were incorporated in the 1973 NHS Reorganisation Act and various circulars issued by the DHSS. Section 10 of the 1973 Act stated that Health and Local Authorities had a duty to co-operate "to secure the health and welfare of the people of England and Wales". Joint Consultative Committees (JCCs) were to be established with members from both authorities to advise parent authorities on the planning and operation of collaborative services. Each service had a duty to provide the other with the appropriate health or social work skills. It was at this point that the hospital social workers were transferred to the employment of the local authorities. The organisational links were to be assisted by common boundaries. The structure of local government in England and Wales was also being changed at this time and the new organisation and boundaries were to come into being on April 1st 1974 the same day as the new health structure. Where possible the new Area Health Authorities and the new

authorities responsible for social services, non-metropolitan counties, London boroughs or Metropolitan districts, were to have similar boundaries - the famous principle of co-terminosity. Collaboration had finally become a statutory duty not just a pious hope.

The New Framework of Collaboration and the Establishment of the Joint Finance Scheme

The new collaborative framework in general and the joint finance scheme in particular emerged from the increased concern with the changes in need discussed earlier in this chapter, and in a general climate of greater central government interest in social planning and desire to influence local plans and services. The Conservative Government elected in 1970 had a new emphasis on planning and policy analysis (Booth 1979). Programme planning and budgeting was introduced into the DHSS in 1971. This was an attempt to improve the use of resources in the public sector by introducing more rational criteria for decisions on resource allocations (Banks 1979). This eventually led to the production of the Consultative Document "Priorities for Health and Social Services in England" in 1976 described by Lee (1977) as the first systematic presentation of national guidelines and indication of resources available for health and social services. In 1975 the Central Policy Review Staff had published "A Joint Framework for Social Policy", an attempt to promote a coherent national social planning policy. Inequalities of provision within and between the different Regions of NHS had been a concern since the report of the Porritt Committee. The Resource Allocation Working Party (RAWP) was set up to devise a new formula for allocating health resources and, in its report, published in 1976, it recommended ways in which financial allocations to the different regions might be used to promote provision both more equal and related to need.

The Joint Consultative Committees were intended to be part of the process of improving collaboration and thus the use of resources. DHSS Circular HRC (74) 9 was issued in March 1974, giving advice on the establishment of JCCS, their function and procedures. They were to advise Area Health Authorities (AHAs) and local authorities on "(a) the performance of their duty under Section 10 to co-operate with one another and (b) on the planning and operation of services of common concern". (DHSS HRC (74) 9). Informality of procedure was recommended

and membership was to be between twelve and twenty, drawn mainly from the members of the constituent authorities, although others could be appointed if they had a special contribution to make. In metropolitan districts one JCC covered all services of common concern, but in non-metropolitan counties two were to be established - one for personal social services and school health services, the other for housing and environmental health with representatives of the AHA and the District Councils. The Working Party on Collaboration had discussed whether JCCs should have financial powers over Local Authorities and be able to plan in their own right. Any proposal to earmark a particular sum in a local authority budget for spending in a particular way would have breached the normal principle of full control over spending at local level enjoyed by local authorities, and would have been much resented by them. The majority view on the Working Party was that any extension of the JCCs powers in this way ignored "the constitutional realities" - that health authorities were accountable to the Secretary of State and Local Authorities to the electorate. The circular, therefore, followed the recommendation that JCCs were to be advisory, not executive. The JCCs were to be supported by joint groups of senior officers from the authorities involved.

This new collaborative structure was only slowly implemented throughout the country and it was three years before each of the 104 AHAs had established JCCs. By 1976 63 AHAs had single JCCs and 27 AHAs had established more than one JCC. There were a number of reasons for this. Some were related to the general difficulties of collaboration between two separate organisations which will be discussed in Chapter III. In addition Stewart (1977) suggested that the DHSS had not sufficiently worked out the role of JCCs and that local authorities were not used to, and did not take kindly to, being told to set up a particular administrative structure by central government, whereas this was a familiar situation to Health Authorities. The Director of Social Services for Newcastle-upon-Tyne described JCCs as "ambling along like camels in a bureaucratic desert" (Roycroft 1978) and the complexity of the new structure could certainly be daunting. In London there were particular problems of boundary overlap. For example, the London Borough of Richmond came under three AHAs in two different Regional Health Authorities. Hampshire AHA related to one County Council, thirteen District Councils and six Health Districts. The simplest

structure was where a single district AHA related to a Metropolitan District as in Newcastle-upon-Tyne.

A major problem, however, emerged as lack of finance available to promote collaboration in a worsening economic climate and David Owen, Minister of State for Health 1974 - 76 labelled JCCs "talking shops without money". The needs of clients/patients alone were not sufficient inducement to collaborate more fully. At Owen's initiative a working group in the DHSS discussed methods for introducing money for spending jointly by health and social services authorities (Willmott 1979). The DHSS evidence to the Layfield Committee of Enquiry into Local Government Finance in 1975 included the suggestion of cross-financing of local authorities by health authorities and the Secretary of State, Barbara Castle, floated the idea at a conference of Health Service administrators in mid-1975. Consultations were undertaken with Local Authority Associations and Regional Health Authorities (Willmott 1979).

The joint finance scheme was launched by DHSS circular HC (76) 18: LAC (76) 6 Joint Care Planning, issued in March 1976. It was described as a consultative circular, although it urged that authorities should take action on the proposals. One reason for this may have been that the worsening economic situation was already affecting authorities, the International Monetary Fund Team was soon to visit Britain, and it was politically useful to the government to introduce a new source of finance at this time. (This circular and the subsequent DHSS HC (77) 17 will be discussed in detail in the next section). In the same month, March 1976, the Consultative Document "Priorities for Health and Social Services in England" was published. This document set out resources available to health and social services and targets to be met by these services. In particular it sought a transfer of resources from the acute services to the "priority care groups", - the elderly, mentally handicapped, mentally ill and children. Joint finance was specifically mentioned in the document as a device to encourage joint planning for these groups by health and local authorities. Despite the standstill in many areas of public expenditure, the growth allocation to the NHS in 1976/7 was 2.6% and to the personal Social Services 4%, in recognition particularly of the rising numbers of the elderly and the increasing sophistication and cost of medical treatment (DHSS 1976).

In June 1976 it was announced that £8 million, out of the total allocation for health services of £3,800 million, would be made available for joint finance in that financial year. In the latter part of the year economic gloom deepened and joint finance became one of the few elements of growth in the two services. Consultations continued between the DHSS, local authorities and health authorities, and as a result the second definitive circular was issued in May. The provisions of this circular which established joint finance on a firm basis will now be examined.

Policy Instruments

The circular issued in May 1977, DHSS HC (77) 17; LAC (77) 10, consolidated and simplified DHSS HC (76) 18: LAC (76) 6, issued in March 1976 and it remained the basis for the joint finance scheme during the period of study with minor modifications which will be described. Joint financing was eventually put on a statutory basis by Clause 3 of the 1980 Health Services Act which empowered District Health Authorities to make grants to local authorities or voluntary organisations for projects of common concern.

Paragraph I, Section I, of DHSS HC (77) 17 sets out the conceptual basis for the structural arrangements that follow and enunciates "only by full collaborative planning in partnership can health and local authorities devise and implement effective complementary patterns of service". Paragraph 2 discusses the role of JCCs and Paragraph 3 recommends the establishment by JCCs of Joint Care Planning Teams (JCPTs) in order to develop joint planning further. Membership of JCPTs may be drawn from the officers of both authorities and can be extended to any individual with knowledge relating to the service being planned. The aim should be a strategic approach which will provide guidelines for officers engaged in drawing up operational plans.

Section II deals with joint financing. It states that the scheme springs from the recognition that the different methods of financing in health and local authorities may hinder joint planning and emphasises the need to overcome these difficulties at local level.

> "In essence, joint financing is designed to allow the limited and controlled use of resources available to health authorities for the purpose of supporting selected personal social services spending by local authorities. The criterion by which an AHA will use the money allocated to it for joint financing will be that the spending is in the interests of the National Health Service as well as the Local Authority and can be expected to make a better contribution in terms of total care than if directly applied to health services". (Paragraph 6, HC (77) 17).

Voluntary organisations may also benefit from these arrangements with local authority agreement. It was projected that by 1980/81 £40 million would be available under the scheme. Regional Health Authorities would specify joint finance resource assumptions to AHAs, who would, in turn, notify local authorities through the JCC.

Appendix I outlines in greater detail arrangements for joint financing. Generally, support for capital projects under the scheme is to be to a defined and predetermined extent. No firm guidelines are laid down about the amount to be contributed. 60% is suggested as a reasonable figure, but 100% will be accepted, (paragraph 13, Appendix I, HC (77) 17). Revenue support is to be for a limited period, initially not exceeding five years, but agreements may be reviewed after three years, to decide whether support may be extended up to seven years in total. (Paragraph 18, Appendix I, HC (77) 17). The possibility of further extension has been permitted by DHSS circular HC (79) 18: LAC (79) 18. Under this circular the Secretary of State will consider requests for extensions, provided that the AHA and the local authority, advised by the JCC, agree that this would be more in the interests of local needs than any new use of the equivalent sum and that "the circumstances justify adoption of an exceptional recourse". There is no attempt to define what such circumstances might be and the increased flexibility which this later circular introduced into the existing scheme will be discussed in the final chapter. Normally revenue support is to be on a tapering scale but no specific guidelines are laid down and again flexibility is expected. A similar flexibility is suggested over the balance between grants given to capital and revenue schemes. These grants need not be limited to either revenue schemes associated with capital projects such as the staffing costs of a new hostel for the mentally ill, or capital projects associated with joint financed

revenue schemes. (Paragraph 16, Appendix I, HC (77) 17). Arrangements are suggested for the joint use of National Health Service land and property.

A condition of major importance is that the local authority (or voluntary body) accepts a firm commitment to undertaking continuing financial responsibility when the support from joint financing ceases - as long as that particular activity is continued by the local authority (paragraph 6b Appendix I HC (77) 17). Joint financing is discretionary and there is no obligation on either authority to undertake projects recommended by the JCPT or JCC. (It will be clear from the discussion of the structure for approving joint finance applications in Hampshire in Chapter VI that it is most unlikely that in Hampshire recommendations will be made by the JCC or JCPT which are not fully supported by the constituent authorities). If the whole of the joint finance allocation is not spent in a particular year, the health authority will normally be required to make available the shortfall in future years. When a shortfall is foreseen early in the financial year the health authority may plan to use joint finance for a normal health service purpose in that year and then divert an equivalent sum in future years to joint finance. An unplanned shortfall late in the financial year may be carried over by the authority into the next year, using the methods normally available to them for carrying over an under-spending of their revenue cash limit.

If the local authority is agreeable, funds may exceptionally be used for a primary health care purpose directly contributing to collaboration between the two authorities, such as part of the capital cost of a health centre providing accommodation for staff from both authorities. Both must agree that this project is more necessary than any other social services use of the money. In this case the AHA, not the local authority, takes on the responsibility for continuing support once allocation from joint finance has ceased. Special permission was required for this use of joint finance (paragraph 11 Appendix I, HC (77) 17), at first, but in DHSS circular HC (79) 18 LAC (79) 11 it was agreed that this special permission was no longer required. There was an extension of this possibility of joint finance support for health purposes in a letter from the DHSS to health and local authorities dated 20th March 1978. This agreed that where a social services

project supported by joint finance cannot be implemented without expenditure by the AHA on a complementary health service activity, that health expenditure itself shall be eligible for support. This has been used particularly to provide clerical support for social workers in health bases, since such support is the responsibility of the AHA.

Since the scheme was introduced at a time of economic restraint, the 1977 circular recognises that this will make it difficult for local authorities to undertake the revenue commitments of the numbers of new capital schemes which the Secretary of State might expect in a balanced joint finance programme. It is therefore accepted that initially joint finance may be used for revenue activities not requiring capital investment, for existing services otherwise at risk or to support capital projects already begun by local authorities. "There is also scope for short-term projects of limited duration which carry no continuing commitments and, where appropriate for evaluation of experimental services". (Paragraph 9, Appendix I, HC (77) 17). Although a purpose of the joint finance scheme is to shift resources and expenditure from health to social services authorities, and there would be expected to be an increased financial burden on local authorities as a result of taking up the revenue consequences of some joint finance schemes, no commitment is made to increase the total of expenditure approved for Rate Support Grant purposes. However, the circular does comment that the changing balance between health and social services expenditure over time will be taken into account in reaching decisions about public expenditure (paragraph 19 Appendix I, HC (77) 17). The general effects of the economic situation on joint finance, will be discussed elsewhere in this study.

The joint finance scheme had a mixed reception. The Institute of Health Service Administrators commented in August 1976 "In general the earmarking by the DHSS of NHS funds is to be deprecated. The present arrangements should be regarded as exceptional and tentative". The introduction of the possibility of using joint finance for primary health care purposes into the 1977 circular - it had not been mentioned in the 1976 Consultative Circular - was, according to David Townsend, Special Adviser to the Secretary of State, 1976-8, an attempt to increase the health side's enthusiasm for the scheme (Wilmott 1979). The British

Association of Social Workers welcomed the scheme as imaginative, but felt it did not go far enough in promoting joint control and operation of services. Just over half the allocation was taken up in the first year of operation, 1976/7. This reflects the scheme's introduction well into the financial year when local authorities' expenditure plans might already be determined, but the increasing economic difficulties, culminating in the International Monetary Fund's visit to Britain in November 1976, may have been a factor in stimulating take-up to some degree later in the financial year.

In Chapter IV the way the joint finance scheme operated in Hampshire will be described. However, in attempting to evaluate the scheme's contribution to increased collaboration and innovative working, it is necessary first to consider what is meant by collaboration and innovation. This will be undertaken in the next chapter.

Summary

This chapter has described the historical background to the health and personal social services and the integration of the individual administrative structures of each service, culminating in the Local Authority Social Services Act 1970 and the National Health Reorganisation Act 1973. Reasons for the increased need for the separate services to collaborate have been discussed, and the new collaborative framework set up in 1974 has been set out. The policy instruments of the joint finance scheme and the motives for its introduction in 1976 have been particularly examined.

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CHAPTER III. THE CONCEPTS OF COLLABORATION AND INNOVATION AND THEIR USE IN THIS STUDY

This research project was concerned with evaluating the effectiveness of the joint finance scheme in promoting an increase in collaboration between health and personal social services in the county of Hampshire, and, in addition, with examining whether joint finance aided innovatory ways of working. The first task in the research was to clarify the concepts of collaboration and innovation, and to form operational definitions of the concepts which could be used to examine collaborative and innovative activity resulting from the joint finance scheme in Hampshire. Without such clarification and definition the findings of the fieldwork could not be systematically examined. The key dimensions of the concepts are the range of activities which may be included in the concept, the underlying philosophies and attitudes of the different bodies and individuals involved in that range of activities, and the structural factors affecting them. This chapter is based on bibliographical study but forms an integral part of the total research.

The Concept of Collaboration

The Concise Oxford Dictionary defines "collaboration" as "working in combination with". The first report from the Working Party on Collaboration set up in 1971 distinguished between collaboration and co-ordination, the former being working together, the latter being working independently but in harmony. (DHSS 1973). Wistow (1982) sets out a more elaborate definition of four types of collaboration:
First, collaboration as sharing of services, that could be provision of professional skills like nursing to other services, or the operation of support services jointly or on an agency basis:
Second, collaboration as co-ordination of service delivery, a need intensified by the changes since 1948 in medical and social care described in Chapter II:
Third, collaboration as joint planning, that is, separate agencies preparing together a single plan for the development of services for which they are responsible, arising in response to the need to develop comprehensive systems of care, particularly community care:
Fourth, collaboration as joint prevention, becoming more important in a time of resource restraint.

Wistow's definition of collaboration encompasses the most wide-ranging and flexible definition of the range of collaboration and matches the flexibility and potential wide range of the joint finance scheme. Any one collaborative project may have elements of more than one of these analytically separate types of collaboration in it.

However collaboration cannot occur in a vacuum. The environment in which it takes place cannot be detached from the collaborative activity and vitally affects its quality and quantity. Therefore environmental factors must form part of any operational definition of collaboration and these will be considered in the next two sections.

General Factors Affecting Collaboration

Both Thomas and Stoten (1973) and Kahan (1980) have pointed out the importance of ascertaining the individual philosophies and attitudes which are to be found in agencies that are collaborating. Thomas and Stoten suggest that if the main purpose of health services is seen as offering a series of specialist, curative medical services to the sick, then collaboration will necessarily be over only a limited range of obviously interdependent activities. If it is seen as the promotion of good health, then the range of collaborative activity becomes much wider, since health is related to every human activity. Both strands are present in the National Health Service, but it was suggested in Chapter II that the second view has been gaining ground, partly in response to changing needs. The implications of this view are, of course, that collaboration may need to be much wider than just between health and social services, and Stewart (1977) makes this point. Housing and education are services whose activities are vitally linked with health care. Already in May 1978 David Townsend, Special Adviser at the DHSS, speaking at a conference organised by the Disability Alliance on joint funding (sic) for people with severe disabilities, agreed that the joint finance scheme, directed at collaboration between health and social services, need to be made more flexible to include housing more easily. Experience in Hampshire showed that it is possible with a complaisant AHA to fund collaborative initiatives, such as the Housing Visitors Scheme discussed in Chapter V, where the local housing departments could be beneficiaries of joint finance. However, for the health services these schemes might largely come under the heading of joint

prevention and this might be seen by some AHAs as too distant an advantage, especially if they preferred a narrower definition of collaboration.

Kahan (1980) suggests that services go through three developmental stages - curative, preventive and promotional. She asserts that health and education services are moving into the third stage, whereas the personal social services are still focussed on prevention. The different stages have different implications. At the curative stage, concern will be with crisis measures, obtaining resources and setting up on organisation. Prevention will require some co-operation with other services, but at the promotional stage all services may need to unite to secure the development of individuals and families in society, and differences may be of emphasis only. Discontinuities in the development of separate services may therefore make collaboration more difficult.

Collaboration is not just a matter of stage of development but also of attitudes. Kahan suggests that health and social services may, because of their different tasks and different public image, recruit different types of people. There may be overlap, but the "centres of gravity" will be different. Existing training tends to reinforce the differences and each service learns a special vocabulary. Webb and Wistow (1981) have demonstrated how differently the concept "community care" can be defined from the different perspectives of health and social services. For the health service it usually implies an expansion of residential care to prevent blockage of acute beds in hospitals. For social services it means the development of day care and domiciliary services to avoid institutional care. Webb's study of collaboration in community care (1978) shows how wide the gap might be between the archetype of anti-bureaucratic, judgmental general practitioner, and that of the non-judgmental semi-professional social worker.

Other general factors affecting collaboration are the degree of substitutability between services, the availability of resources and the example set by a superior agency. Because of the overlap of areas of work discussed in Chapter II, staff in the same service, with skills overlapping those of workers in another service, may be used in preference to those workers in another service. So psychiatrists may prefer to use community psychiatric nurses who have, or are believed by psychiatrists to have, an understanding of social issues, rather than social

workers, and avoid any problems of inter-service collaboration. This is also more likely to occur if the supply of community nurses exceeds that of social workers (Warwick 1982). Similar substitutions may happen in institutional care. The shortfall of 120 beds for the elderly in the Portsmouth Health District according to DHSS norms produced a greater need for and greater use of places for the elderly in Part III homes in the South East Division of the Social Services Department (JCPT minutes 5.12.78).

Bleddyn Davies (1968) pointed out the substitutability of special housing for the elderly and home helps instead of residential care, and this principle was followed in the development of a number of special housing schemes in Hampshire, known as Part 2½ schemes, funded by joint finance. In the final chapter of this study it will be argued that workers in separate services need to learn to collaborate. To do this they must have opportunities to practise collaboration. If a worker in the same service is substituted for one in an administratively independent service, as in the case of community psychiatric nurses and social workers, opportunities for practising inter-agency collaboration are reduced. The use of home helps and specialised housing offers opportunity for practising collaboration between housing and social services departments which do not occur if residential homes are used instead to care for elderly people. Of course, such opportunities may not always result in <u>improved</u> collaboration but it seems unlikely to occur without them, and whether they improve collaboration or not, they must necessarily increase it.

The availability of resources to each service, and hence for collaboration changed markedly during the 1970s. Mackenzie (1979) suggests that the 1973 NHS Reorganisation Act represented the 1960s mood of faith in the future but it has been implemented in a time of pessimism and economic depression. Webb and Wistow (1981) showed that personal social services expenditure doubled in the 1960s and 1970s from a low base, but that threequarters of the growth in the 1970s took place from 1970 to 1976. In the 1975 White Paper on expenditure, it was suggested that 2% per annum growth was needed simply to cope with the increased demand brought by the growing numbers of elderly and other vulnerable groups. This did not provide for any improvement in standards of service. The 1976 Priorities Document confirmed expenditure plans

of 2½% for social services but only 1.8% for health from 1977/8 onwards. By the 1980-81 Public Expenditure White Paper health spending was expected to rise 3% over 1978 levels but personal social services spending was to be reduced as part of a reduction in total local government expenditure of 3%. The level of joint finance was protected. The implications of these reductions, and particularly the greater reduction in social services allocations, will be discussed in relation to local services in Chapter IV. Lee (1977) commented even in 1976 that collaborative planning is untried in a time of economic stringency and is probably less easy then.

In 1968 the Department of Health and Social Security was formed by amalgamating the Ministry of Health and the Ministry of Social Security. As the central government department responsible for health and personal social services its attitudes to collaboration might be influential. Both Levitt (1976) and Mackenzie (1979) agree that the merger did little immediately to alter the actual working of the department. Both services were still dealt with separately. Levitt suggests that there has been some improvement since an internal reorganisation in 1974 but Mackenzie is more pessimistic, and comments "This is the outcome of a deep underlying fissure in English institutions and the gap cannot simply be closed by doodling with administrative structures". (Mackenzie 1979). A further difficulty is that the DHSS has more control over health authorities than over individual local authorities, although this control may in practice be less than was once thought, as Haywood and Alazewski (1980) demonstrate. This will be explored more fully in the next section. The DHSS is only slowly overcoming obstacles to encouraging collaboration within its own administrative structure, but it has at least been able to protect the financial allocations to joint finance in a difficult economic situation. This is one measure of its commitment to collaboration, and the support it has secured for it from politicians.

Factors Affecting Collaboration between Health and Social Services at Local Level

Some obstacles to collaboration at local level between health and social services had been removed by the time of the reorganisation in 1974. Each individual service had become administratively more integrated, there was a statutory framework for collaboration and

co-terminous boundaries where possible to facilitate it. There was a general climate of support for collaboration and a recognition of the needs that made it appropriate. However, as Lee (1977) comments, from 1974 onwards it was still the feasibility, although not the desirability of collaboration, that was largely at issue. Obstacles to collaboration of a general nature were discussed in the previous section. This section sets out those affecting planning and operation at local level.

The lines of accountability are different for health services and social services and this links with the different financial bases of the two services. The National Health Service is funded out of taxation and this was distributed during the period of study through Regional Health Authorities to Area Health Authorities. This enabled a fair degree of control over spending by the DHSS. Members of Area and Regional Health Authorities were appointed, not elected, and accountability was through the Secretary of State ultimately to Parliament. Local authority services are funded partly by general government grant, the Rate Support Grant, and this varies over time as a proportion of their income. In 1965/6 it was 51%, in 1975/6 67% (Lee 1977). This is a block grant, and although central government can exercise some controls, particularly over loan sanctions, and tries to advise on service development, for instance, through departmental circulars, local authorities fiercely defend their freedom to determine their own priorities. The rest of local authorities' income comes from locally raised rates and charges for services. Members are elected locally and responsible to the electorate. The single central government department responsible for both health and social services, the DHSS, has therefore far less control over the activities of social services departments than health authorities.

The different role of members in each service can cause misunderstandings locally. The consensus-seeking health authority contrasts with the combative politics of local authorities. Although Sir Keith Joseph, Secretary of State for Health and Social Services from 1970 to 1974, made it clear that local authority members nominated to the AHA were not representatives of the bodies nominating them, but generalists, their presence did cause confusion in practice. This is demonstrated in Booth's (1981a) study of Calderdale.

The relationships of the tiers in each service to each other and to the tiers in the other service have been examined by Rowbottom and Hey (1978). They saw the absence of clear counterpart units in the other service as a major problem. There was no equivalent in the local authority structure to the Regional Health Authority or the Health District, and no body like the District Management Team. Rowbottom and Hey identified three different levels of collaboration needed; the first that of individual cases, the second that of systems to deal with particular kinds of cases, and the third comprehensive with territory-wide focus. They stressed the need to be clear about the nature of the collaborative tasks, and the officer level required. Two officers had special responsibility for collaboration - the Health Services Liaison Officer (HSLO) in the Social Services department, and the Specialist in Community Medicine (Social Services) in the AHA. Webb (1978) points out the complexity of their task and both he and Rowbottom and Hey suggest that unless these officers are appointed at a high enough level in their respective organisations, they will not have the necessary access to top-level planning. (The positions of these two officers in the area under study will be discussed in Chapter IV. Rathwell and Reynolds (1979) point out the implications of the rank of officers on the JCPT. If they are too low in their respective hierarchies they may have good knowledge of the services but difficulty in obtaining their seniors' support. If they are too high, they may have sufficient power, but insufficient knowledge of detail.

Co-terminosity is another related and significant factor in collaboration. Rowbottom and Hey point out the different natural divisions of health and social services. Health districts, the lowest tier from 1974 to 1982, usually focussed round a District General Hospital, or a group of smaller hospitals. This area would be smaller than that of a local authority but larger than that covered by the area office of a social services department. In turn, such an area office covered a larger area than the typical health centre or general practice. As already indicated, co-terminous boundaries were sought in the 1974 reorganisation, and where they were achieved, collaboration was facilitated. Kelly (1978) found that of the areas with co-terminous boundaries among the respondents of his survey, 77% spent 100% of joint finance allocations and the rest spent most of it. Among areas with non-co-terminous boundaries, only 27% spent the full allocation. The 1982

health service reorganisation moved away from this principle in favour of increased decision making power at district level. Wistow and Webb (1980) have argued that this may have a very deleterious effect on collaboration. In many areas the social services department will have to collaborate with a larger number of independent health authorities but without extra resources to cover the extra administrative costs. This must increase the workload of senior officers in social services departments in particular, and will make county-wide planning more difficult.

It is interesting to note that, although a consortium arrangement for pooling joint finance for a trial period of one year had been agreed by the County Council and the new District Health Authorities (DHAs) in Hampshire, already at the first meeting of the new JCC in May 1982 the chairman of Portsmouth Health Authority gave notice that his authority might prefer to withdraw after the trial period.

The planning styles and systems of health and social services are another element in the collaborative process. Planning in the National Health Service is much more formalised than in local government, and most operational planning is done at district level with recognised input for it there. District Plans were drawn up from March to July, then forwarded to the AHA for examination and comment. Area plans went to Region in October. This cycle was difficult to integrate with the pre-budget planning of local authorities where initial estimates are drafted in September and priorities between departments determined around Christmas. Barnes (1977) and Thomas and Stoten (1973) both pointed out the likelihood that JCCs would only be involved after district plans had gone to the AHA and that JCCs would comment on separately produced, completed plans, rather than contribute to the process of producing a joint plan. This certainly happened in Hampshire. (Wright 1982).

After consultation at the JCC has taken place, the plans of either AHA or social service department may be altered independently. Those of the AHA may be altered by Region, those of the local authority by the amount of the Rate Support Grant settlement. Indeed allocations under the Rate Support Grant and under the RAWP guidelines to the health authority may pull in opposite directions. (Townsend, 1979). In the period 1976-8 the Rate Support Grant favoured urban areas, whereas the RAWP guidelines favoured Regional Health Authorities with shire

counties. This could produce an AHA with joint finance money available but a local authority with reduced income, making takeup difficult. The Rate Support Grant 1980/1 redressed the balance in favour of rural areas.

In contrast to the requirement to produce annual plans laid on health authorities, local authorities are only requested to produce three year plans by the DHSS. (Rathwell and Reynolds, 1979). The greater independence of local authorities of the DHSS discussed above results in a much greater local variation in plans and planning. Headquarters staff are usually those involved, not those at operational level as in health authorities, and the relative roles of members and officers in a particular authority will be determined by local party political tradition, the personalities of the director and committee chairman, and the style of budgeting of that authority. (Webb 1979a).

At operational levels too, effective collaboration will depend on commitment and receptiveness, and well-developed concepts of need. (Rogers 1978). The structural factors described above will play their part. However there are factors specific to this level. Webb's survey of twelve AHAs and eighteen social services departments for the Personal Social Services Council (Webb 1978) found good collaboration where a large number of agencies had contributed to the care of one individual, or in an acute situation, where two or three professionals acted as a primary care team. He found poor collaboration at operational level where there was need for strategic as well as operational planning, such as over hospital discharges and admissions, where the range of resources and services were inadequate, and where there was inappropriate action by some professionals involved. His recipe for improving collaboration at this level included shared training, the development of multi-professional teams with a co-ordinator and more joint seminars and discussion groups.

Norton and Rogers (1981) in their study of collaboration in five Health Regions over projects for the elderly referred to in Chapter I, also emphasise the importance of local teams with access to administrative support and responsibility for the full cycle of research, policy making, planning, programming, implementation and evaluation. Lonsdale et al. (1980) do strike a note of caution, making clear the need for the investigation of the different types of teams that are found in the

health and social services, and of the benefit of this method of working to the consumer over separate contacts with individual professionals which might allow more choice.

The Operational Definition of Collaboration used in this Study

Potentially the range of collaborative activity may extend over sharing of services, co-ordination of service delivery, joint planning of services and joint prevention. However, whether or not the full range of collaborative activity is undertaken by collaborating agencies will depend on the different philosophies and attitudes present in those agencies and in the individuals acting on behalf of them. Factors such as the availability of resources for collaboration, the substitutability of services and the example set by a superior agency will modify the quality and quantity of collaboration. In relation the health and personal social services in England specific structural factors affecting collaboration will be differences in accountability and financial base, the relationship between the tiers in each service to each other and to tiers in the other service, co-terminosity of boundaries and planning styles and systems. The definition of collaboration used in this study will be:- an activity which may embrace any, or all of sharing of services, co-ordination of service delivery, joint planning and joint prevention carried out by two or more administratively separate agencies which is directed towards providing an appropriate combination of health and social care for its recipients, and which will be modified by attitudinal and structural factors in the collaborative environment.

The Concept of Innovation

The second concept employed in this research is that of innovation. It is certainly a popular view that the joint finance scheme was designed as a pump-priming mechanism to promote new developments for particular care groups. This view was expressed by County Councillor Samuels at the Hampshire Social Services Committee Meeting on 18th July 1980 when he expressed dismay at the projected use of joint finance to offset the effect of cuts in the resources available to local government. The expectation that joint finance would assist innovation will be discussed in the last chapter but in order to assess whether joint finance did aid innovation in Hampshire, some discussion of the concept

of innovation and the factors impinging on it is necessary. This clarification underpins particularly the case studies described in Chapter V.

For the purposes of this study innovation will be defined as a conscious change, not one that occurs by default or omission. It is important too to distinguish between the innovative idea, the formulation of policy, the obtaining of resources and the implementation of innovation. Innovation in a particular geographical area like Hampshire will have a particular meaning dependent on the previous development of services in that area, and it will have a different meaning for health services than for social services. Webb has suggested a typology of innovations (Webb 1979):-

1. Changes in clinical practice within the context of existing service systems of specialisms. An example of this might be a decision by social workers and community nurses attached to a terminal care unit to offer support to bereaved relatives in small groups rather than by individual visiting.

2. New forms of intervention or outputs, possibly involving new specialisms such as the appointment of a community psychiatric nurse attached to a psychiatric day hospital. The Housing Visitor Scheme discussed in Chapter V was found to be another example of this type of innovation.

3. Restructuring of patterns of service to produce new systems of provision. Salford's restructuring of its mental handicap services to produce a district handicap team and a service offering an emphasis on rehabilitation is an example. (Swire 1978).

4. New inputs, for instance the power given to Social Services Departments under the Children and Young Persons Act 1968 to assist families financially.

5. Restructuring of existing inputs to produce existing outputs in a different way. The restructuring of the Hampshire Social Services Department undertaken at the end of 1981 ending the former Divisional structure and amalgamating some area offices is an instance.

Only the first of these five types of innovation can be undertaken without use of formal policy processes. As Webb points out (Webb 1979) different forms of innovation will be generated and adopted in different

ways in response to different stimuli. For this reason the barriers to different types of innovation will be different. He suggests that innovation is a product of the interaction of the nature of the problem to which policies are a response, the perceived effectiveness of policy outcomes and the underlying ideology and value base upon which theories and criteria of assessment are based. Innovation may occur if there is a shift in any one of these three.

Factors Impinging on Innovation

Ideology is a key factor in determining which demands for innovation will be met. Hall et al (1975) have pointed out that issues accepted as legitimate for government intervention will vary with the ideology of the government. Webb (1979) describes the triumph of a social democratic welfare state ideology in 1948 in which structural theories of poverty dominated and the client was seen as the passive recipient of service. Now, he suggests, an increased emphasis on individual responsibility and a resurgence of some of the ideas and anxieties current in the 1830's, as described in Chapter II, are challenging the welfare state ideology and producing, for instance, a greater emphasis on non-statutory provision and interest in informal care networks. As Donnison and Chapman wrote in their classic study "Social Policy and Social Administration" (1965) "demands that are met shape the service, not all demands made on it".

Financial constraints are a second factor affecting innovation and are related to ideology. The 1979 Conservative government's decision to make more resources available for law and order and less available for social services had an ideological base. However those constraints in themselves may promote particular types of innovation. Webb (1979) suggests that in the current climate of financial stringency and heavy demand innovations emphasising resource conservation and input substitution become more valued than those concerned solely with improving standards of care. Hill (1980) points out financial constraints can intervene between the innovative idea and its implementation, particularly where there is a split between central government as initiator and local government as implementor. The Chronically Sick and Disabled Persons Act 1970 provides an example of central government empowering local authorities to take on a wide variety of responsibilities to the disabled,

but without the necessary extra resources. Donnison and Chapman (1965) assert that innovation can only take place if there is a constant increase in resources, as only then is there the time and energy available for innovation. However Webb's first, third and fifth type of innovation described above may not require extra financial resources although if they require staff time this may need to be produced by extra resources. It will be described in Chapter V how lack of staff time prevented all the joint finance earmarked for joint training in Hampshire being spent.

Organisation structure and management style are linked factors affecting innovation, and size may be related to these. Less bureaucratic and more participative organisations may be more conducive to innovation although Webb (1979) quotes some evidence to challenge this, in particular Moch and Morse (1977) suggesting that larger organisations tend to have higher rates of adopting innovations. Their larger budgets give greater flexibility and their size necessitates decentralisation, task differentiation and staff specialisation. Davies et al (1971) in their study of services for the elderly in County Boroughs found that Boroughs with a strong commitment to social services - usually Labour controlled - and a resultant high reputation which attracted good staff, and Boroughs with low residential provision, hostility to its expansion, and heavy demand, were most innovative in terms of community provision.

Individual personality is a fourth factor affecting innovation. Different writers give different degrees of importance to this factor and it will have different weight at different stages of innovation. Donnison and Chapman (1965) were clear that change was "largely brought about by people who work in the Services", although they saw that when more capital investment or cash payment was required the providers were more dependant on "external" participants. The providers have most influence on the innovative idea and in the implementation of innovation, less at the stages of obtaining resources and policy formulation. Norton and Rogers, (1981) laid great weight on the importance of key individuals and of implementors in general in collaborative innovation. They rely on the promotion of individual initiative at operational level to overcome the impediments to collaboration - the different styles and objectives of health and social services personnel,

the complexity of the collaborative structures and the effect of shortage of resources. However it is not clear from their work why such an individual response to a particular problem could not arise at middle or senior management level equally well. Their "bottom-up" model tends to ignore the problem of policy formulation and obtaining resources by a small group that is part of a larger organisation which attempts to determine policies centrally. A "top-down" model does, however, ignore the very real influence of the implementors on the final form of an innovation, which will be evident in the Housing Visitors Scheme described in Chapter V. It is more related to reality to define innovation as a process of introducing a deliberate change which provides a new service or a new way of organising an existing service in a defined geographical area. This is a definition that will be used in this study.

Finally it is important to note, as Webb (1979) does, that all innovation implies costs. Switching of resources may not only be detrimental to existing activities, but may also be disproportionate to the new outcome. Webb instances the search for alternatives to residential care in the 1970s which deflected attention from improving care within the residential system. Norton and Rogers too sound a cautionary note:- "The effects of an innovation and the evaluation of its outcome may always be uncertain because of the difficulties of quantification and objectivity of judgement" (Norton and Rogers 1978).

Conclusion

In this chapter the concepts of collaboration and innovation have been clarified and related to the operational context of the field of health and social services. Collaboration has been defined for the purposes of this study as an activity which may embrace any or all of sharing of services, co-ordination of service delivery, joint planning and joint prevention, carried out by two or more administratively separate agencies, which is directed towards providing an appropriate combination of health and social care for its recipients, and which will be modified by attitudinal and structural factors in the collaborative environment.

Innovation for the purposes of this study has been defined as a process of introducing a deliberate change to provide a new service or a new way of organising a service already existing in the area of

study. As with collaboration environmental factors, particularly availability of resources, organisational structure and management style significantly affect the quality and quantity of innovation. Other important factors are prevailing ideologies and individual entrepreneurs.

The next task of this study is to examine the operation of the joint finance scheme in Hampshire from mid 1976 - April 1982 in the light of these concepts.

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CHAPTER IV. THE JOINT FINANCE SCHEME IN HAMPSHIRE AND FACTORS AFFECTING ITS OPERATION. 1976 - 82

Informally there was collaboration at all levels between the health and social services, other County Council and District Council departments. Formally collaboration was focussed on the Joint Consultative Committee (JCC) composed of members from the AHA, the County Council and District Councils, and serviced by the officer Joint Care Planning Team (JCPT), whose members came similarly from those different authorities and included representation from the Health Districts. The JCPT set up a number of sub-groups. One of these - the Joint Finance Executive (JFE) - had the responsibility for processing applications for grants from the joint finance allocation made by the RHA to the AHA for spending on projects of joint concern to both health and social services, as described in Chapter II.

The JFE was established in January 1978 and its terms of reference were as follows:-

"1. To promote the concept of joint financing.

2. To draw up working rules for processing schemes for joint financing and to ensure that the criteria used for selection are widely disseminated.

3. To call for schemes for joint financing in two stages:-

   a) in outline so that the Executive may be able to assess, firstly whether the scheme is acceptable in principle, and secondly, what additional information is required.

   b) in detail in order to assess its viability in the light of all relevant information now to hand and so that the method of financing may be devised.

4. To recommend to the JCPT schemes, which may be accepted for joint financing and those which fall outside the criteria.

5. To report to the JCPT on the balance of joint funds available and any likely changes in the balance due to delays in the implementation of agreed schemes.

6. To develop a long-term programme for the utilisation of joint funds.

7. To examine the 'success' as far as possible of jointly funded schemes."

If its recommendations to the JCPT were approved, they should be forwarded to the JCC and thence to the constituent authorities of the JCC. They had each in turn to approve the recommendations before they could be implemented. The JFE met about every six weeks, before the JCPT. Until it was set up a sub-group of the JCPT on Projects, established in mid-1976, had considered applications for joint finance. However, this group had inadequate administrative back-up and managed to function efficiently only because many of the early allocations were to schemes already worked up by officers of the Social Services Department but placed in jeopardy because of the economic situation at the end of 1976. As more totally new applications came before the sub-group the workload was too great. The new sub-group was set up and a Project Development Assistant (PDA) was appointed to work under one of the Assistant Directors in the Social Services Department (ADSS) to provide "administration services concerning co-ordination of applications, consideration, and maintenance and monitoring of the overall financial record of joint financing transactions in liaison" with the health authorities. (Paper on Joint Finance for JCC 24.5.1982).

Membership of the JFE

Membership of the sub-group was drawn from officers of the Social Services Department including the ADSS, PDA and the Health Services Liaison Officer (HSLO). One or more officers from the Treasurer's Department of the County Council attended regularly. Members from the health side were the Specialist in Community Medicine from the AHA with responsibility for liaison with the Local Authority (LCP), who acted as chairman, a representative from the AHA Treasurers section (successively ATa, ATb, ATc) and an administrator from the AHA who provided secretarial services to the subgroup (successively AHa and AHb). From January 1978 until August 1981 one representative came on behalf of the four Health Districts wholly within Hampshire, in this case an administrator from the Portsmouth Health District (HDA). One representative of the thirteen District Councils was a member of the sub-group but attended less regularly until the latter part of the period of study when a new representative was appointed. Various officials might attend for individual items and sessions but until August 1981 the core membership was very stable. Most changes occurred

in the representative of AHA Treasurers. This representative was frequently a participant in controversy in the JFE. Some of this must be due to his role, but some may be ascribed to his position as a new member entering an established group. Personality also plays its part. ATb aroused evident feelings of impatience and irritation in other members of the group which ATc did not elicit.

In September 1981, in anticipation of the National Health Service reorganisation expected in April 1982 when the AHA would disappear and Health Districts become authorities in their own right, the membership of the JFE expanded. Henceforth it included a representative from each Health District, not just one administrator representing all. These were:- the previous representative from Portsmouth (HDA), the District Community Physician from Southampton Health District (DCP), an administrator from Basingstoke Health District and the Treasurer from Winchester Health District. Secretarial services to the sub-group were now provided by an administrator from Basingstoke Health District, who were to continue this role after April 1982 on behalf of the other District Authorities. By January 1982 the HSLO had ceased to attend as her post had disappeared in the reorganisation of the Social Services Department in autumn 1981. (The implications of this will be discussed later in this study.) To strengthen the County Council representation one of the Deputy Directors of Social Services now attended the JFE also. Some, but not all, of those on the JFE were also members of the JCPT. LCP, ADSS, HDA and DCP were members of both.

Members of the JFE were, of course, all members of many other committees, within their own authorities, on other joint committees of the various authorities or on voluntary bodies. They were all part of a network of formal and informal links which acted upon each other and formed part of the very complex structure of collaboration which Wistow and Webb (1980) and Lauerman (1980) have both commented on. This had advantages and disadvantages. It was a great advantage, for example, to a voluntary body to be able to tap easily the knowledge about joint finance which members of the JFE possess, and to have a supporter actually on the JFE when the application was discussed. ADSS was a member of the managing committee of the Stonham Housing Association. Applications for assistance from joint finance came very regularly to the JFE from this body and produced some ribaldry at his expense.

At the JFE on 2.3.82 the chairman and other members were obviously uneasy about ADSS's involvement in one particular request for the Stonham Housing Association and sought confirmation from the Deputy Director of Social Services also present that the department did support this application. Other officers outside the JFE suspected that some applications obtained preferential treatment (comment of Service Planner, Health District) and it was evident that applications supported by powerful members of the JFE could be agreed without passing through all stages of the normal application process in sequence. The application for funding a social worker for St. Dismas was made verbally only, without an application form at the JFE on 19.8.80. Conflicts could arise for members of the JFE who were also members of other subgroups of the JCPT and this will be considered later in this chapter when relationships between the JCPT and its subgroups are examined.

Conflicts could also arise within the JFE between professionals and administrators. The LCP and HSLO were professionals, the other members were administrators. The HSLO was particularly concerned about the propriety of administrators being involved in decisions about professional matters. The investigation for applications for grants for training were always left to HSLO and LCP on the ground that the assessment of these was a professional task. However there were areas where it was less clear which skills were required. Money spent on placements of younger physically handicapped people in institutions not run by the County Council (non-county placements) were a case in point. At the JFE on 3.6.1980 there was a vigorous discussion about this. Such placements involve decisions on both professional and financial matters. Some members wished to leave the decision on policy over these placements to the JCPT sub-group on the physically handicapped, composed of professionals, whereas others felt that finance remained such an important factor that the JFE must be involved.

Processing of Applications

A paper before the JFE on 13.6.1978 set out the formal procedure for processing applications. It suggested that a Health Care Planning Team or other body, such as a voluntary organisation, could obtain advice about a scheme they wished to put forward from the service planner in the Health District or from PDA at Social Services headquarters. The

initial proposal should be on the appropriate form (for an example see Appendix IV) and should state the general objectives of the scheme, the benefits expected, the rough costs, who had been consulted and the staff involved. The form should then be sent to the service planner or PDA. It might need to be worked up more fully with help from the service planner or an adviser in the Social Services Department. Authority would be needed from the JCPT to involve County Council personnel who might be needed in planning such as architects. Social Services headquarters would need to be involved in capital schemes. Schemes must conform to Social Services department policy and the County Council manpower provisions. The service planner or PDA must secure the approval of the Management Team at the AHA for the applications and then forward it to the JFE. Schemes could be processed throughout the financial year. From time to time it was suggested, for instance in the report on the first two years of joint finance submitted to the JCPT in May 1978, that projects should be submitted only at specified times in the year but the JCPT did not approve this. Surrey JCC had found a system of considering applications once a year unsatisfactory and this was known to ADSS and HSLO.

In September 1978 discussions were started on delegating authority from the JFE to Health Districts and Social Services Divisions but proposals made in July 1979 for the reorganisation of the National Health Service made it apparent that the benefits of such delegation would be short-lived, particularly because there was bound to be a period of instability after such a change. Discussion therefore ceased. The proposals for allocating joint finance once reorganisation occurred in April 1982 will be discussed in the final chapter.

The PDA reported (interview 2.5.80) that applications normally came straight to him. He then sent them to the Health District and Social Services Divisions for the area from which the application came. After discussion they were returned to him and put before the JFE. He estimated that the time scale was two months to the JFE meeting and a further two months for subsequent final approvals. However it was clear that while PDA did handle the bulk of applications, schemes did reach the JFE by other routes. Other members of the JFE, particularly HDAa, AHA a/b, HSLO (especially in relation to training) and LCP produced applications not on the agenda at JFE meetings, and ADSS

on occasion introduced verbally a scheme for which no forms as yet existed. This might occur because the JFE member was also a member of the voluntary body presenting the scheme; because, like HSLO, they were recognised as having special responsibilities in that area; or because that member had better established links with the grant-seeking body. A Health District might route its scheme through the AHA officers rather than through PDA if time was short before a JFE meeting.

It became evident as late in the period of study as 2.3.82 that not even all members of the JFE shared the same perception of how the process of application should be carried out. An application from a voluntary body to extend its facilities by means of a joint finance grant was before the JFE. This application had not been seen by the appropriate Health District. DCP then questioned whether all applications came to the JFE even if not supported by one of the two authorities. ADSS felt that they should, on the ground that the applicant then secured right of appeal to the JCPT if there was disagreement about the worth of the application. The County Council Treasurer's representative commented that if proper procedures were followed and the application form signed by both parties, the application could not come forward if one signature was missing. DCP commented "We need a ruling on the rules" and said that the Health District he represented would not put forward schemes it did not support and could not have such schemes foisted on them. It was agreed that there would be a discussion on procedures at the next meeting - outside the period of study. ADSS's perception of the applications procedure was interested in that he had been a member of the JFE from the start. It seems to reflect his pragmatism and wish to secure as much freedom to manoeuvre as possible. Health Districts would resist ADSS's interpretation because they would wish to maintain their autonomy in their own Districts and not be controlled in any way by the JCPT. Moreover any allocation of joint funds reduced the total theoretically available to individual Health Districts and they would not therefore wish joint finance to be spent, in their own area particularly, on a scheme they did not support.

The difficulty of determining what constituted adequate local consultation at Health District and Social Services Divisional level, and whether it had occurred, was a question that often exercised the JFE. It arose most often in relation to bids for money for Primary

health care from the Health Districts. There was confusion among some health administrators, the reasons for which will be discussed later in the chapter, about whether consultation was needed over primary health care applications, which it generally was. Basingstoke Health District was a particular offender in sending in bids which had not been discussed with the Division. On 6.7.81 the HSLO succeeded in deferring consideration of an application by Age Concern for financing Volunteer Field Officers because she asserted that consultation had so far only taken place at AHA and Social Services headquarters level, not Health District/Divisional level. LCP mentioned (interview 19.3.80) that difficulties occurred also when a Social Services Division wished to put forward a scheme which was liked by one of the Specialist Advisers, but did not conform to Social Services policy, as it should do under the JFE terms of reference.

Local Guidelines for Joint Finance

National guidelines for the joint finance scheme have been laid down in various government circulars. but local guidelines have been established within these. In the report prepared for the JCPT in May 1978 the policy enunciated was that of extending and strengthening existing services or establishing new ones, not underwriting existing services. It was not defined exactly what "underwriting" an existing service meant - another example of the desire on the part of the administrators, particularly ADSS, to retain flexibility in operating the scheme. The priority care groups for Hampshire were the elderly, the mentally handicapped and the physically handicapped. Individual schemes must conform to Social Services Department policies and the County Council manpower provisions. Limitations of manpower were at that time the principal factor in ensuring joint finance was spent on capital or one-off schemes rather than revenue schemes. Because tapering of joint finance in Hampshire was almost without exception on the basis of 100% funding from joint finance for the first two years of the project, 75% in the third year, 50% in the fourth year and 25% in the fifth year, the Social Services Department might have embarked on revenue schemes which would cost them nothing in the first two years, relying on an improvement in economic conditions over that period to start paying for the scheme in the third year. The limitations on manpower

prevented them taking this gamble. During the period of study Hampshire always funded capital schemes 100%, not 60% as suggested in the circular.

At the JCC of 28.5.80 it was requested that the AHA and Social Services Department should jointly produce a set of guidelines for the future use of joint finance. This task was passed by the JCPT, to the JFE. Some members of the JFE felt that this was an inappropriate task for the JFE - an executive, not formally a policy making body. But who else was to do it? The JFE certainly possessed more appropriate knowledge than the JCPT. Also, as HDA pointed out, if the JFE drew up the guidelines it could exert more control over them. After this there was no further demur. These guidelines were presented to the JCC on 17.11.80 and accepted, apart from the section on voluntary organisations. (The reasons for the rejection of that section will be discussed in the section of this chapter dealing with relationships with the children's sub-group). The paper set out the national guidelines and gave details of allocations by care groups from 1976 to September, 1980, and details of the anticipated future allocation. For the future it suggested that the flexibility of operation in Hampshire so far should be maintained, particularly in view of the County Council's inability to accept schemes with recurring revenue consequences at that time. Increased support might be given to Social Services capital projects which would not otherwise be developed in the then current economic situation. Funds should continue to be made available to primary health care schemes, as sanctioned by DHSS circular HC (79) 18 and HC (77) 17. All schemes would in future be reviewed annually and allocations adjusted for the effects of inflation.

Changing economic pressures brought about modification of the local guidelines. These pressures will be discussed in more detail in the next section. Their local effect was to reduce the local authority's budget and, at particular times, put in jeopardy the continuance of some social services. In 1979/80 an allocation of £103,400 was made from joint finance to support existing social services in lieu of reductions in service to meet Social Services Department cash limits. In June 1980 a further crisis occurred when cuts of £1,337,000 were required in the Social Services Committee budget by the Policy and Resources Committee of the County Council. At the JCC of 7.7.80 it was agreed that £301,000 of the £456,000 remaining in the joint finance allocation

for that year could be used to underwrite social services in danger of closure that would affect the operation of health services. Thereafter it seemed to be accepted by members of the JFE that the principle of underwriting services would be implemented on occasion. For example, in a discussion on 12.1.82 on future areas that might be considered for joint finance, ADSS suggested that using joint finance to bolster the County Council deficit should be added to the list of possibilities.

Occasionally there was anxiety that the applications for joint finance might exceed the allocation. In December 1978 this seemed imminent, and it was suggested by the JCPT that planning guidelines based on identified need, and financial guidelines, reflecting anticipated available monies, should be drawn up. However as only £274,620 remained unallocated for 1980/81, these guidelines were to be used for subsequent years only. In fact, owing to a number of factors to be discussed in a later section of this chapter, during the period of study no scheme fell because of lack of money and no more specific planning guidelines, other than those already detailed in this section, were in operation. There was an occasion in August 1980 when the JFE asked the JCPT to arbitrate on which schemes should be accepted for primary health care joint financing, as the demand exceeded the part of the allocation set aside for primary health care at that time. On this occasion all schemes were accepted, although for some of them funding was delayed until the next financial year of 1981/2.

External Factors affecting the Joint Finance Scheme

a. Economic

Throughout the period of study the economic state of the nation as a whole was in decline, and this was experienced in the social services as a decline in real income and by health services as a reduction in growth. Joint finance allocations were protected by central government and this made this source of finance of even greater interest to the AHA and the Social Services Department. LCP pointed out (interview 19.3.80) that the allocation to Hampshire for 1980/81 of £1,144,000 exceeded the growth allocation to the AHA of £333,000. The temptation to use the allocation to maintain existing services threatened with cuts was irresistible, and mention has already been made of occasions on which this occurred. In each case the AHA received a quid pro quo.

In 1979/80 this was an extension of the tapering period for primary health care schemes funded by joint finance from five years to seven years, allowed under DHSS circular HC (77) 17 para. 18, although this was not normally operated in Hampshire. In July 1980 the AHA was to receive £150,000 of the remaining joint finance uncommitted balances for 1980/1 for non-recurring primary health care schemes. That this was a quid pro quo was openly acknowledged at the JFE of 19.8.80, not so openly at the Social Services Committee of 18.7.80. Councillor Samuels at that Committee made the point very strongly that joint finance was for innovation and experiment, not to underwrite budgets. The Director of Social Services defended the action by referring to a speech of the Secretary of State for Social Services at a recent conference which suggested that the national allocation of £48 million for joint finance should go to make up the £90 million reduction in the Social Services budget.

Economic pressures dogged many attempts at rational planning of services. At the JFE of 22.7.80 a representative from the County Treasurer's Department made a plea for planning "direction of spend" for joint finance. ADSS and HDA countered this by instancing attempts to plan services for the elderly in Portsmouth which failed after much staff input because of national government financial constraints and local government manpower restrictions. Another officer from the Treasurer's Department described the activities of the JFE as "crisis management" (interview 24.3.82). The May 1978 report of the JFE on two years of joint finance acknowledged that pragmatism had dominated decisions because of a lack of clarification of the problems of service delivery for each client group, and an estimate of the resource implications thereof. However, ADSS's view (quoted by PDA 2.5.80) was that as targets were so big, exact accuracy of aim was not required. A more planned approach was mooted for post-1982 reorganisation joint finance, and this will be discussed in the last chapter.

Economic stringency influenced the attitude of the local authority and prevented it taking up a large number of schemes with revenue consequences. At the JCC of 14.12.78 the County Treasurer pointed out that the joint finance revenue takeup represented growth of 0.5% per annum in the Social Services budget at that time, and, if the total joint finance allocation was used for revenue schemes, it would represent

growth of 1½% per annum. This would take up all the money available for growth for the Social Services Committee. At the JCPT of May 1978 it had been suggested that the County Council manpower restrictions were, in fact, the greatest limitation on taking on recurring revenue schemes. However, even if manpower restrictions were lifted the Social Services Department clearly would not want to limit its freedom of action by committing all growth to the collaborative area. During the period of the study the Social Services Committee were, therefore only prepared to agree to a very limited number of recurring revenue projects. For instance, they decided arbitrarily to limit the use of joint finance to provide social workers attached to new health service developments only, such as the Travelling Day Hospital for Psychogeriatrics in the Portsmouth Health District in 1982. Any expansion of existing health services requiring more social work support would not have that support funded from joint finance.

Mention was made in Chapter III of the greater reduction in resources for the Personal Social Services compared with the NHS, particularly since the advent of the Conservative Government in 1979. This affected collaboration at local level. The AHA was pushing ahead with a programme of replacing large mental handicap hospitals by a number of small locally based hospital units. The Social Services Department was quite unable to match this with the necessary training facilities, or to offer an appropriate number of places in hostels or sheltered housing to those patients in the large hospitals whom they acknowledged as the responsibility of the local authority because of their level of handicap. (Paper for JCC 28.5.80). Some heath services administrators felt this reflected a lack of will as well as a lack of money (comment of Senior Planner, Health District 24.10.80) but those closer to Social Services headquarters recognised the discontinuity in resources as being the major factor. (Comment of AHA administrator 7.10.81). The officer in the Corporate Planning Department charged with facilitating collaboration certainly saw this as the greatest problem for collaboration.

b. Political

Just as national economic events impinged on the working of collaboration so did national political events during the period of study. Throughout the period, Hampshire County Council was Conservative controlled.

In May 1979 a Conservative government was elected. By political conviction, but perhaps also through financial expediency in a time of economic difficulty, Conservatives place far more emphasis on the use of volunteers to undertake tasks in the health and social service fields than do Labour administrations. This pressure to use volunteers and voluntary organisations filtered right through to the JFE. The JCC on 7.7.80 had called for a report on the possibility of using in succeeding years

> "a proportion of the uncommitted balance of joint funding (sic) money to enable the voluntary sector either to take over the running of the County Council Services which would otherwise have to be discontinued or to provide substitutes for those services".

The officer from the Corporate Planning Department responsible for facilitating collaboration attended the JFE on 16.9.80 to share in discussion of the preparation of this report. He acted as secretary to the Children's sub-group of the JCPT which had half-prepared a paper on joint finance and the voluntary sector. He wanted the JFE to take this over and incorporate it into the report. He was explicit that the paper was both an attempt to disarm pressure from councillors for increased use of voluntary resources and an attempt to put the point of view of the officers - that voluntary organisations can only complement, and not substitute for, statutory services.

Throughout the discussions by the JFE on preparing the report, which finally appeared before the JCC of 17.11.80 with the title "Guidelines for Joint Finance", there was realisation of the political need to recognise councillor and member enthusiasm for the voluntary sector. A section of a table showing joint finance commitments for 1981/2 to 1983/4, which broke these down into allocation to recipient organisation, was deliberately omitted. It showed that in 1983/4 funds committed to voluntary organisations stood at £9.4 millions compared with £160.9 millions for the County Council and £44.8 millions for the AHA. It was agreed that this merely reflected lack of forward planning by voluntary bodies because of their lack of administrative staff, but that it would be politically inexpedient to make these figures public, for fear of misinterpretation. Similarly, a paragraph on the need for monitoring was moved from the end of the paper to the middle and reworded, so that it did not seem as if voluntary organisations were being singled out for this, although officers felt that voluntary

organisations did in fact need closer monitoring because it was not necessarily built into their systems as in the AHA and County Council.

It is the view of the Association of County Councils, and one shared by members of Hampshire County Council that joint finance distorts priorities. (JCC minutes 14.12.78). However, as HSLO pointed out (interview 23.5.80), politics can also distort priorities, and it is the interplay of political, economic, administrative, and ideological factors which determine what is a priority and what is not at a particular time.

Issues Internal to the Scheme which Affected Collaboration at Local Level

The rules or guidelines for the operation of the joint finance scheme at both national and local level ensure that the scheme operated in one way rather than another, and some of these created difficulties for those operating the scheme, and produced its particular local "flavour".

a. Financial

It was explained in Chapter II that DHSS circular HC (77) 17 paragraph 10 instructs that if the allocation of joint finance for a particular year is not spent in that year, the AHA will be required to make the amount of the shortfall available for joint financing in subsequent years. The unspent amount will be carried over to the next financial year as part of the 1% carryforward of revenue allowed to health authorities. This meant that spending of the allocation was of the greatest interest to the AHA, less so to the Social Services Committee, for whom no penalty for underspending existed. Wistow (1981) found that one AHA felt this gave local authorities an advantage over the AHA and might encourage health authorities to accept proposals by local authorities of limited value to health authorities to avoid problems of underspending. This anxiety about underspending became greater as the day for reorganisation in April 1982 approached, because the DHAs with their smaller budgets did not have so much leeway for carrying over large sums. This was evident at the JFE of 27.10.81 when the DCP argued for a more promotional attitude to joint finance so that the money should be spent and large balances avoided.

Slippage was a part of the problem of underspending. It was inevitable that some schemes would not come to fruition exactly as planned,

TABLE 1. Schemes Approved by 31.3.82.

Care Group	No. of Schemes[1]	No. Recurring Revenue	Pick-up, by agency
Children	7	0	0
Mentally Ill	16	5 (31.25%)	2 LA 2 AHA 1 voluntary body
Elderly	59	19 (32.2%)	15 local authority 1 AHA 2 voluntary body 1 LA/voluntary
Mentally Handicapped	28	12 (42.8%)	12 LA 2 AHA 1 AHA/LA
Physically Handicapped	23	11 (47.8%)	4 LA 1 AHA 6 AHA/LA
Other (2)	36	13 (36.1%)	3 LA 9 AHA 1 RHA
TOTAL	169	60 (35.5%)	36 LA 1 LA/Vol 15 AHA 7 LA/AHA 3 Vol 1 RHA

1. includes 9 schemes where money is a contribution towards maintenance of existing/programmed service.
2. includes lump sum allocations for primary health care schemes - counted as 2 schemes only.

and this could have its uses. Funds could be overcommitted in any one year and treasurers could still be sure they would be able to meet their commitments. During the debate on the guidelines in the JFE during October 1980 the idea of a contingency fund, for unexpected demands on the scheme, was rejected because slippage usually ensured there was no need for this. However, it could never be predicted how great slippage would actually be. At the JCC of 24.5.82 it was reported that there was an underspending of £250,000 on the joint finance scheme for 1981/82 which was attributed to slippage. The treasurer's representative made it clear at the JFE of 2.3.82 that underspending might not always appear in the accounts as payments could be made and funds committed in advance. ADSS commented with a warning note that committing funds did not mean they were necessarily spent. In 1980/81 £175,000 had been set aside for spending on non-community placements for the elderly and physically handicapped. By 23.3.81 this had not been used and the JCC were asked to recommend that it be used instead on improving staffing in various home and training centres for the mentally handicapped.

The rule that most affected the shape of the joint finance scheme, and the one which has been commented upon by all those who have written about the scheme, is that relating to takeup. The fact that the local authority has to be prepared to take on the revenue consequences of the majority of joint financed schemes was a severe limitation in view of the national economic situation discussed earlier. It inevitably produced a bias in favour of capital and one-off or non-recurring revenue schemes, which increased as the cuts in social services budgets bit deeper. In the list of schemes presented to the JFE on 2.3.82 (that is, at the end of the period of study) this was evident. Of the seven schemes for children all involved non-recurring revenue. Of the sixteen schemes for the mentally ill, the only two taken on by the local authority dated from the early days of the scheme and of the three other revenue schemes, two were picked up by the AHA and one by a voluntary organisation. Table I shows the details of the take-up by agency and the percentage of recurring revenue schemes in each care group and in total.

A further difficulty was that collaborative schemes eligible for support by joint finance could only be schemes which stood referred to the Social Services budget with the exception of primary health care schemes. This meant that useful schemes might fall because they

involved an agency other than Social Services, although a similar population to that served by social services might be involved. A proposal to fund extra places at Standford Grange, a residential community taking mainly adult offenders was before the JFE on 17.3.81. It was not eligible for joint finance because it was regarded as in the sphere of the Home Office rather than the DHSS, despite the plea of the secretary of its Management Committee that it operated "in the indefinable, rather 'grey' area where Social Services, the Health Service and Probation all meet". (Application letter before JFE 17.3.81). The Housing Visitor Scheme described in Chapter VII is another example of the difficulties produced by schemes needing to be taken up by Social Services. The workers in this scheme formed a bridge between housing and social services and could equally well have been located in Housing departments. As part of a joint financed scheme they had to be social services employees but did not form part of the normal range of the department's employees. At a time of manpower restriction the local Social Services division wished to exclude them from its number of field workers as they were not employed as social workers, yet there was no other place for them to be counted. If a joint takeup by housing and social services had been possible or a joint funding, as opposed to joint financing, arrangement had been made, there would have been fewer difficulties. Occasionally a blind eye was turned to the limitation of joint finance to social services and primary health care schemes. Funding of lifts in residential homes for the elderly did not really fall into these limits except in the broad sense of joint prevention (comment of health administrator - interview 7.10.81). If the wider definition of collaboration proposed in this study including joint service delivery, joint planning and joint prevention, is accepted, this limitation on collaboration to almost exclusively health and social services, reduces the area of possible collaboration very considerably.

Pilot Schemes proved to be one way of assisting the County Council with the difficulties of revenue takeup. Pilot schemes provide a way of testing new concepts or ways of working without a formal final commitment to their continuance. The most significant example of a pilot scheme in Hampshire financed by joint finance was the Care Attendant Scheme which offers extra assistance to disabled people and their families in their own homes. Initially it was funded 100% for two years from

joint finance but was extended to a third year to enable a full research assessment to be made. At the JFE on 3.6.80 it was pointed out that if a scheme is renewed indefinitely it is out of step with the original circular DHSS HC (77) 17, but the scheme had proved a great success and would now be impossible to end. Eventually negotiations between the County Council and the Health Districts concerned produced an arrangement whereby the Care Attendant Scheme became a normal joint financed scheme i.e. funded at 100% for 2 years, then tapering over three years, but being picked up jointly by health and social services. DCP commented "Pilot scheme - a way of securing 100% joint finance for five years". In fact Tidball (1981) suggests that the option for renewal of a joint finance scheme as far into the future as necessary is already provided for by DHSS circular HC (79) 19. This issue will be discussed further in the final chapter of this study.

b. Primary Health Care Schemes

In DHSS circular HC (77) 17 it was permitted that, in exceptional circumstances, joint financing might be used for a primary health care purpose, and in that case the AHA would take up the revenue commitment if appropriate. (Other details relating to this provision are set out in Chapter II). Willmott (1979), quoting a Special Adviser to the Secretary of State for Social Services 1976 - 79, David Ennals, suggests that this was put in the regulations to keep the health side "sweet" by offering extra resources to a hitherto low priority area. It also went some way to meet a criticism voiced by Langston (1978) that a strategy for moving resources from hospital to community provision must include the community health services, for which expenditure had actually fallen by 0.5% in 1975-77. How was this provision of the circular dealt with in Hampshire and what did the exceptional circumstances prove to be?

An early mention of expenditure on primary health care was following the notification to the AHA by the RHA on 4.5.1978 that a further £224,000 had been added to Hampshire's joint finance allocation for 1978-9. Such a large additional sum after the beginning of the financial year was an embarrassment and threatened to increase the AHA carryover to an unacceptable level. A number of options for dealing with this windfall were discussed by the JCPT on 23.5.78 and, following recommendations by the JFE, it was decided that it should be divided between

bringing forward Social Services capital projects, primary health care schemes, and schemes from voluntary organisations and district councils. At the JCPT of 4.7.78 approval was asked for by the AHA Area Team of Officers that £100,000 could be spent on non-recurring items as it was not possible to commit the £200,000 to revenue expenditure at such short notice. The exceptional circumstances obtaining in 1978 were, therefore, a sudden extra allocation which social services manpower restrictions, budget limitations and lack of staff time for planning prevented being used in the normal way.

In the summer of 1980 the circumstances were rather different. The cuts facing the social services department at that time have been discussed earlier in this chapter and the expedient chosen of allocating £151,000 to primary health care schemes in exchange for supporting the social services budget from joint finance. At the JFE on 22.7.80 there was some discussion of the principles upon which this money should be allocated. How much say might the social services department have in the choice of primary health care schemes? Should the money be used for growth or to support existing services? Eventually the decisions were that the money should be used only for supporting existing services or planned developments at risk because of the AHA's financial position, and that if the proposals for schemes were restricted to this, then it was not necessary for health districts to consult with local social services divisions. At the next JFE of 19.8.80 when the list of bids from the health districts were before the committee, some social services members expressed their doubts that bids for carpeting a health centre or resurfacing a carpark were really in the spirit of the original circular. Other members reminded them of the essentially political nature of this quid pro quo and all the bids went forward to the JCPT for approval.

Southampton Health District were unhappy with the limitations on the spending of joint finance on primary health care schemes. During 1980 the District Administrator was in correspondence with the Minister of State for Health, Dr. Gerard Vaughan, with Sir David Price, MP for Eastleigh as an intermediary. The District Administrator pressed for the use of joint finance for primary health care on a recurring and indefinite basis. However the Minister, in a letter of 10.6.1980, stated that:

> "the permanent and unrestricted diversion of part of the funds for primary health care purposes would represent a potential loss to the personal social services and a misconception of the purpose of joint financing".

In a later letter he agreed that there was no objection in principle to spending a proportion of the allocation on primary health care on a regular basis, provided normal rules of tapering applied.

The possibility of spending part of the allocation in this way, and the criteria for doing so, were a recurring theme at meetings of the JFE during 1981. It proved difficult to ensure that health districts and local social services divisions understood that such expenditure must be exceptional, and the JFE of 11.8.81 recommended that this was reiterated to local officers. However, local officers did not have any firm guidelines to help them in deciding what might be exceptional. The JCPT in October 1981, despite a request to do so from the JFE, reached no agreement about general principles, except to say that joint finance would not be available to purchase cars for the use of community nurses. As the administrator from Portsmouth on the JFE remarked on 27.10.81, they would have to depend on "caselaw" based on past experience to guide them. By the end of the period of study it seemed to be accepted, particularly if large balances were accumulating, that primary health care proposals could be put forward, and would be considered, on the same basis as those for the care groups, but with the limitation in DHSS HC (77) 17 as a brake on too great an outlay on primary health care.

c. JFE - Responder not Initiator

Under local guidelines the JFE was designed to respond to proposals made by other bodies, statutory or voluntary. Theoretically, apart from the general mandate to promote joint financing in its terms of reference, it had no power to correct any imbalance in the proposals coming forward. If every proposal made was concerned with mental handicap, for example, provided it met the criteria and money was available, it had to be accepted. As LCP commented at the Social Services Committee of 30.1.81, the distribution of the allocation reflected the aspirations of those putting forward schemes. The only amounts earmarked for particular purposes were the £15,000 per annum for training, discussed in

Chapter V, and £10,000 per annum for research projects agreed in 1980. In fact, as suggested earlier in this chapter, any attempts to plan rationally were likely to be doomed to failure by the rapidly changing economic situation.

However, although the JFE and JCPT as bodies could not initiate, individual members, by virtue of their membership of other bodies and committees, could be powerful initiators. The role of ADSS in bringing projects for the Stonham Housing Association before the JFE has already been cited. Officers' influence could be felt in curious places. The application by Andover and District Multiple Sclerosis Society for money to purchase a holiday caravan resulted from PDA buying one of the Society's raffle tickets in a pub, and suggesting to the seller that the Society could tap joint finance for this. However, there were limits to officers' initiatory activities. Members of the Social Services Committee on 18.7.80 wished to see more joint financing of schemes from voluntary organisations, and officers felt forced to point out that they were limited to considering schemes actually put forward.

Relationships Between the JFE, JCPT and JCC

The relationships between the JFE, JCPT and its other sub-groups, and the JCC were not static. They changed over time under the influence of the changing economic and political pressures already described, and under the influence of the different personalities who acted in them. The effect of administrative change, such as the reorganisation of the Social Services Department in the autumn of 1981 and the reorganisation of the National Health Service in April 1982 were important. The full effects of the latter change are outside the scope of this study but some effect was felt far in advance of the legal change from AHA and Health Districts to independent District Health Authorities. Even as far back as July 1979 discussion of arrangements for delegating more power over allocating joint finance to Health Districts and Social Services Divisions were ended because of impending NHS reorganisation. Mention has already been made in this chapter of the expansion of membership of the JFE in September 1981 in anticipation of the establishment of the District Health Authorities.

As the parent body of the JFE, the JCPT must approve all its recommendations before they can progress to further approvals and implementation.

The JCPT might be used as an arbiter between health and social services members of the JFE if they disagreed about a particular scheme. The proposal to establish a Transition House for the Physically Handicapped in the Southampton area is an example. This was part of a package promoted by Southampton Health District which included a District Disability Team, a Care Attendant Scheme and residential accommodation. Social Services planners were unwilling to support it, feeling they already had a sufficient proportion of projects for the young disabled in their budget. Agreement could not be reached at the JFE so the decision was made at JCPT. During the period of study only a very few schemes were arbitrated on in this way, largely because if the applications procedure was correctly followed, disagreement at local level would normally prevent schemes even coming to the JFE. The dislike of the most senior members of the County Council of joint finance on the ground that it reduces local autonomy ensured that officers tried to keep a low profile and to keep conflict to a minimum in disbursing joint finance. There is no evidence of conflicts about joint finance occurring beyond the level of the JCPT. (Interview with PDA 2.5.80).

The JCPT can overturn a recommendation of the JFE, but again this happens rarely. A request for joint finance support for a non-county placement by Basingstoke Health District in May 1981 was rejected by the JFE on the ground that the local Social Services division was not agreeable and had not been consulted. The Basingstoke District Community Physician protested at the JCPT and eventually funding was agreed for one year. With the expanded membership of the JFE it is possible that such disagreements will occur and be resolved there, rather than coming to the JCPT.

Although the County Treasurer's representative who sat on both JFE and JCPT commented that there was little difference between the two, because the JCPT did so little strategic planning (interview 24.3.82) differences were apparent to this observer. The JCPT seemed much more a meeting of independent authorities who would wish to report back. The JFE was a working group. The JCPT provided a forum where information could be exchanged and progress reported. It could also be used as a sounding board for floating new ideas which could then be worked up by one or more of the constituent bodies. This occurred, for example, over the Boyatt's Wood hostel, a proposal by the Social Services department

to provide residential accommodation for the physically handicapped, to be funded by joint finance, discussed at the JCPT of 19.5.81. However, the expanded JFE was beginning to show some of these characteristics too. At the JFE on 27.10.81 members exchanged information about the progress made over future funding of the Care Attendant Scheme in the various Health Districts, and at the JFE of 13.1.82 it was being suggested that because of the composition of the reorganised JCPT, after April 1982, the JFE might have a more active and powerful role, with more delegated power.

The only other sub-group of the JCPT which met with anything like the same regularity as the JFE was the sub-group on Children's Services. The relationship might be described as one of sibling rivalry. The Secretary of the Children's Sub-group suspected that the relatively small allocation of joint finance to schemes for children (3% of the total in contrast to 23% for the elderly at 31.3.81) is due to obstruction by the JFE. The Director of Social Services suggested to the Social Services Committee on 30.1.81 that, as children's services consumed over 40% of the Social Services budget, joint finance money was being used to make up shortfalls for other client groups. The reception by the JFE of the Children's Sub-group's paper on joint finance and the voluntary sector (mentioned earlier in this chapter) was cool and dismissive, and large parts of it were cut. The disagreements over this paper on the guidelines for joint finance finally surfaced at the JCC on 17.11.80. County Councillor Samuels was critical of the tone of section 2.6. on the voluntary organisations. This prompted the Chairman of the JCPT Children's Sub-group to reveal that the paper on guidelines had been based on the earlier paper of the Children's Sub-group and to suggest that the original paper did more justice to voluntary organisations. After discussion the guidelines paper was accepted apart from section 2.6. and a more detailed report on this item was submitted to the JCC on 23.3.81. This exchange might be represented as a victory for the Children's Sub-group. It is ironic that officers on the JFE and the Children's Sub-group in fact shared the same attitudes to the voluntary sector.

This rivalry with the Children's Sub-group could cause conflicts of loyalty for members of the JFE who were also members of the Sub-group. Both LCP and HSLO had this dual membership, and HSLO expressed

the difficulties at the JFE on 2.12.80 which discussed the application for the extension by a further year of the Under-Fives Co-ordinator Scheme. This was supported by the Children's Sub-Group. A number of JFE members were critical of the application, feeling that more information about the effectiveness of the scheme was necessary before they were prepared to agree a further allocation. HSLO felt that whether or not the scheme was effective was a professional decision, and that this endorsement had been given by the Children's Sub-group, a body concerned with professional matters. She argued that the JFE must accept that and could only comment upon financial aspects. Having agreed to the scheme as a member of the other sub-group she did not feel able to criticise it now. Other members of the JFE did not have this conflict of loyalties, or thought that the remit of the JFE to monitor schemes provided a rationale for their criticisms. Here also is evidence of a conflict partly due to the different frames of reference of professionals and administrators.

The JCC, the pinnacle of the machinery of collaboration, was in reality the least effective part of that machinery. Hampshire as a non-metropolitan county was entitled to two JCCs, one for Social Services and education with members drawn from the AHA and the County Council, another for environmental health and housing with members drawn from the AHA, and the District Councils. (DHSS HRC (74) 19). However the constituent authorities had decided to combine the two JCCs to form one only in 1977. This was to avoid duplication, and joint finance certainly seems to have been a stimulus to this combination. (AHA minutes 19.5.77). This body did not meet at all between 14.12.78 and 21.5.80 and it seemed to be the imminent financial problems of the Social Services Department, and the pending reorganisation of the NHS which revived it. This reflects the advisory nature of the JCC and the fact that the real power over the allocation of joint finance and over most collaborative activity lay with two of the constituent bodies - the AHA and the County Council. If either of them did not wish to pursue a course of action in the collaborative field, the JCC could not compel them to do so. Thus throughout the period the JCC did not meet, it was still possible for joint finance schemes to be implemented, provided the AHA and the Social Services Committee had given their approval, although technically JCC approval was part of the process.

The letter of the law was observed, in that the Chairman of the JCC approved joint finance proposals during this period. For most of the period of study the Chairman of the JCC was in fact the Chairman of the AHA. The JCC did provide an arena where the difficulties between the County Council and the AHA over the mental handicap programme could be discussed, and the officer in Corporate Planning responsible for collaboration felt it was useful in informing members about collaboration and controlling the JCPT. (Interview 14.8.81). Thus, apart from having a certain public relations value and acting as a "dustbin" for disputes, as Booth (1981a) found in Calderdale, during the period of study, its importance was small.

Differences Within and Between the Health Districts and Social Services Divisions in Relation to Joint Finance

It was evident during the course of this study that there were considerable differences in the attitude to, and use of, joint finance by the four different Health Districts and three Social Services Divisions in the area of the study. With minor boundary differences, the Southampton Health District corresponded broadly to the S.W. Division, the Portsmouth Health District to the S.E. Division, and the Basingstoke and Winchester Health Districts to the Northern Division. Southampton and Portsmouth had been self-governing County Boroughs until the reorganisation of 1974 and their integration with the old county of Hampshire was by no means complete. The Social Services Department had not yet established common forms to be used throughout the divisions. The levels of staffing and type of service offered in the Social Services Divisions were still to some extent influenced by the old structure and by the different problems met in the former County Boroughs and the rural County. Expanding Basingstoke was experiencing the problems of a newly established community. Amalgamation with the County had brought Conservative control to the often previously Labour-controlled urban areas. On the health side, the Health Districts had had since 1974 to develop relationships with each other and with an Area Health Authority, and with an Area Team of Officers who were not in authority over them but yet could exercise some control over their planning and resources.

In addition to these historical and political differences within each service, there were the problems posed by the different philosophies and the different stages of development of each service, detailed in Chapter III. LCP characterised the two different approaches (interview 19.3.80) as a medical model of intervention to change and a social work model of enabling change by others. It is important to remember, however, that neither the health service nor the personal social services are staffed by homogeneous professions. Each service brings together several different professions and types of workers with varying levels of commitment to the dominant model of the service. It was observable at the JFE that administrators from the different services might share perceptions of how to deal with problems and might disagree with a professional colleague from their own service. HSLO and ADSS (not a trained social worker) were often at odds. The Loughborough research found that medical and nursing staff were more critical of joint finance than administrative or financial staff. (Wistow 1981).

Representation of the Social Services Department on the JFE was solely by headquarters staff, but health representation included both AHA and Health District representatives. The JCPT had representatives from all Health Districts. It did seem that representation on the JFE affected the perception and use of joint finance by the Health Districts. It was not possible to determine whether perceptions concerning the usefulness of joint finance had affected the vigour with which Health Districts attempted to secure representation of the JFE at the start. In any event Portsmouth, with a representative on the JFE throughout the period of study, and Southampton, with an energetic and pragmatic District Community Physician who became a dominating figure as soon as he joined the JFE in September 1981, put forward more projects and appeared to have a better grasp of the intricacies of the scheme than the two other Health Districts. The District Community Physician in Winchester was known to be unenthusiastic about joint finance. Basingstoke Health District seemed to have particular difficulties with the scheme. The Assistant District Administrator (interview 28.4.81) felt that the AHA did not represent the Health District's views sufficiently clearly on the JFE, echoing the view of the Southampton service planner quoted earlier in the chapter that some schemes had preferential treatment behind the closed doors of the JFE. Basingstoke presented schemes

to the JFE without prior consultation with the local Social Services division, and there was often contention surrounding its primary health care applications. For example at the JFE of 2.12.80, one of the AHA administrators agreed to contact the Health District to try to make the criteria of the scheme clearer. Basingstoke deliberately offered to undertake the administrative work connected with joint finance on the health side after reorganisation so that it could play a more central role in joint finance. (Assistant District Administrator - interview 28.4.81).

The lack of a matching structure listed in Chapter III as a factor affecting collaboration, made its impact in Hampshire. This is particularly clearly demonstrated in the study of collaboration over services for the elderly carried out at Southampton University for the DHSS. (Wright 1982). The District Service Planner, Southampton, commented (interview 24.10.80) that the Health District had more autonomy than the Social Services Division who had to consult headquarters about virtually any decision to spend money. She felt that Divisional links with headquarters were poor, took too long to operate, and that headquarters staff found it difficult to support innovative ideas in one Division which could not be implemented county-wide. Meetings between Health Districts and their corresponding Social Services Divisions were of different frequency in the different areas depending on the enthusiasm and commitment of the staff involved. It did seem likely that the meetings at six monthly intervals with the Northern Division to discuss joint finance projects, described by the Assistant Administrator of Basingstoke Health District as an improvement, were insufficient to produce close collaboration, and may have been responsible for the underuse of the scheme by this area compared with other parts of the county. All health administrators were united in their feeling that the social services reorganisation of autumn 1981 would make collaboration at local level more difficult. Although this was denied vigorously by Social Services headquarters, that reorganisation, by ending the Divisional structure, was perceived as giving more power to headquarters, while the imminent reorganisation in the Health Service would act in the opposite direction.

Voluntary Organisations and Joint Finance

In the difficult economic climate a Conservative local authority might look to the voluntary sector for help and they were certainly encouraged to do so by central government. (DHSS 1981a). In Hampshire the members of both AHA and the local authority wished to increase the role of the voluntary sector and instructed officers to prepare a paper for the JCC on 17.11.80 discussing how this might be done with the help of joint finance. As was shown earlier in the chapter, officers did not on the whole share members' view of the role the voluntary sector might play, and in the JFE the social services representatives took a more pessimistic view than the health representatives of the viability of voluntary organisations. On 3.6.80 an application was before the JFE from the Portsmouth and District Spastics Society for funds to extend their Work Centre. All social services officers agreed in doubting the ability of the Spastics Society to raise the revenue necessary to operate the Centre once it had been extended. A similar situation arose over the application by Alpha House, before the JFE on 21.1.81, for a pump priming grant of £10,000.

Members did not always appreciate the extent to which voluntary organisations were dependent on public funds. At the JCC on 17.11.80 a number of members were loud in support of the use of voluntary organisations. The Director of Social Services adroitly used the example of the Spastics Society Family Help Unit in Southampton, almost entirely financed by grants from public funds. The Director questioned to what degree the public sector should undertake the underpinning of voluntary organisations, and what should be the official representation on the management committees of such organisations when such a large proportion of funds came from official sources.

There were, of course, a large number of voluntary organisations within Hampshire ranging from very small local groups to large branches of national organisations. A substantial number were benefitting from grants from joint finance ranging from the one-off grant to Winchester Bereavement Support of £250 to the £181,000 paid to the Spastics Society Family Help Unit during the period 1976-81. However whether or not a voluntary organisation did benefit from joint finance was very haphazard. The Secretary of the Hampshire Council of Social Service felt this would always be a difficulty because there was no one organisation

representing all the voluntary groups to negotiate with the statutory authorities. (Interview 30.5.80). Partly as a result, he thought, voluntary organisations only received the crumbs of joint finance. The example of the Andover and District Multiple Sclerosis Society, who heard about joint finance through a chance encounter in a pub, shows how randomly conferred could be the benefits. It was indicated earlier in the chapter how helpful it could be to have a member of the JFE or JCPT on the committee of a voluntary organisation. There was then no formal way of involving voluntary organisations in joint finance in Hampshire. No representative of such an organisation sat on the JCPT or JCC although they were more involved in Health Care Planning Teams.

Conclusion

In this chapter there has been a description of the system set up to allocate the joint finance money available to the area of study, and a discussion of some of the factors affecting this. It is clear that of all the factors described in the operationalisation of the concept of collaboration in Chapter III the one with most apparent effect was that of resource availability. The difficult economic climate which reduced resources available for collaboration, and reduced them most for the personal social services, made rational planning of collaborative ventures almost impossible, created a preference for capital rather than revenue schemes because of take-up requirements and produced an alteration in the local guidelines for spending the allocation, which would permit money to be used to shore up collaborative activity in danger because of cuts. The underlying differences in philosophy and training between the two administratively separate services exercised some effect but it was not so apparent as that of shortage of resources. It may be speculated that its effect might be to prevent collaborative schemes from being considered at all in particular areas of work. In any case, as indicated in the chapter, administrators in both services particularly, might share perceptions which crossed service boundaries. Some of these shared perceptions were due also to the experience of working together gained by members of the JFE particularly. This point will be elaborated in the final chapter.

This study was concerned with the area jointly covered by the Hampshire AHA and Hampshire County Council. It excluded consideration of those areas of the administrative county in other AHAs and therefore of any difficulties produced by non-coterminous boundaries. However, within the area of study the discontinuities between the structure and organisation and the planning styles and systems of the health and personal social services did cause lack of understanding and affected the quality and quantity of collaborative activity. However, again this was overcome to a great degree by those who most often practised collaboration and were most committed to it.

It was a limitation on the widest collaborative activity that only schemes which stood referred to the social services budget, and exceptionally primary health care schemes, were eligible for joint finance. This resulted in some collaborative schemes being rejected although schemes which ran the gamut of Wistow's (1982) categories - from sharing of services and co-ordination of service delivery to joint planning and prevention - were certainly possible under the regulations existing until April 1982. However, the definition of collaboration employed in this study encompasses a broader definition of health and social care which requires a joint finance scheme which permits at the very least projects in these areas of housing and education. The government's proposals for widening the joint finance scheme made public in the Consultative Document "Care in the Community" (DHSS 1981b) and the subsequent circular HC (83) 6; LAC (83) 5 "Health Service Development" will be discussed in the final chapter.

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CHAPTER V. THE CASE STUDIES

Introduction

It was suggested in Chapter I that consideration of two joint finance projects in detail would provide a useful way of examining the scheme at operational level and shed light in particular on whether joint finance did promote innovatory working. The definition of innovation used in this study is the process of introducing a deliberate change which provides a new service or a new way of organising an existing service in a defined geographical area. Both schemes studied were new developments in Hampshire. The Housing Visitors Scheme was a new service in the Southampton area. The "Living, Working and Dying" course was a new training initiative designed to produce improved understanding and therefore improved informal, and possibly even formal, collaboration between health and social services.

In relation to the concept of collaboration in use in this study the case studies might illuminate such aspects of collaboration as the effect of different management styles and structures and the relationships of tiers in each service to each other and to the tiers in the other service. The significance of the different philosophies and the effect of the availability of resources could also be studied.

a) The Housing Visitors Scheme

This scheme involved collaboration between Southampton City Housing Department, the Southampton Council of Community Service and Hampshire County Council Social Services Department, involving particularly the Social Services Area Offices of Woolston and Shirley. The method of investigating the operation of this project has been described in Chapter I.

Development of the Scheme

Prior to the 1974 Local Government reorganisation, a Special Services Section had existed in the Southampton Housing Department which was responsible for accommodation for the elderly in the city. It consisted of a Special Services Officer, an Assistant and a Visiting Officer, whose task was to visit the elderly in non-wardened schemes.

No provision was made for this service in the post-reorganisation department and by 1977 a need for such a visitor was being expressed in the department. This related particularly to the rapid increase of the number of elderly people on the waiting list for purpose-built accommodation - from 1065 in 1976 to 1329 in 1977. In July 1977 the Southampton City Policy and Resources Personnel Sub Committee, following a report from the Director of Housing and the Personnel Manager, agreed to the appointment of two Visitor Officers (Elderly Persons) in the Housing Department. They were to act as peripatetic wardens for the elderly in non-wardened housing schemes. However, these posts were not filled as cuts in local government expenditure made it impossible to fund them. Feelers were put out by the Housing Department to both the District Management Team of the Southampton Health District and the Divisional Social Services Department to see if a more comprehensive approach could be achieved. The Health District did not show much enthusiasm. The Social Services Divisional Management were doubtful. They feared that those filling these posts would be drawn into performing social work tasks and they preferred such tasks to be performed by workers within the Social Services Department.

The Southampton Director of Housing then made an approach to the Assistant Director of Social Services. He was known for, and prided himself on, his pragmatic approach to the objective of maintaining the elderly in their own homes. Moreover, the Social Services Policy Plan published in 1976 had stated that no more Part III houses for the elderly should be built, and that there should be a concentration on community support for the elderly. The Assistant Director was not a trained social worker and had little patience with what he saw as the restrictive professionalism of some Divisional Managers. As a member of the JCPT and JFE he was well aware of the existence of joint finance monies. The Social Services Department was subjected to a manpower freeze at that point but the Housing Department still had approval for two posts. A compromise was worked out by which an application would be made to joint finance for support, the Social Services Department would agree to take up the revenue consequences of the scheme but the staff were to be employed by the Housing Department and subject to its conditions of service.

During the course of the discussion the duties of the posts were modified and extended. The officers were not merely to be a kind of peripatetic warden for the elderly but were to:-

"1. Establish and maintain contact with elderly applicants for purpose-built accommodation so that more sensitive allocations could be made.

2. Identify applicants at risk so that the appropriate support services could be involved.

3. Monitor the dependency levels of those in purpose-built accommodation to make more effective use of housing stock.

4. Develop greater liaison between the Housing Department and Social Services Area Centres".

(Various memos and letters, Shirley Area Office files).

The main objectives of the project were therefore to achieve better allocation and thus more effective use of housing stock, to provide appropriate support services for individuals and to improve co-operation between housing and social services in Southampton. The posts were upgraded from Miscellaneous Grade 3 to AP2 as a result of the expanded duties.

It remained to pilot the scheme through various Committees. It was approved by the Housing Committee on 15th February 1978, the Personnel Sub-Committee of the City Council on 5th March 1978 and the Social Services Committee on 15th April. The JCPT on 23rd May agreed to support joint finance for the scheme on the normal Hampshire basis - 100% for the first two years, 75% for the third year, 50% for the fourth year and 25% for the fifth year - and AHA and Social Services Committee approval followed. There is no evidence of any demur from the health representatives at the JCPT or at the Area Health Authority Meeting. There was some concern in the local health service around this time about the inappropriate placement of elderly people in hospital care (Rogers and Norton 1981 unpublished) and this scheme may have been seen as a contribution to improving allocation in housing, health and social services.

By the autumn of 1978 further modifications were introduced. The Organising Secretary of the Council of Social Service was invited to join the Management Steering Group that had been set up. In addition,

those appointed as visiting officers were to stimulate and develop voluntary care within the community by, for instance, starting neighbourhood support groups, organising day or luncheon clubs, assisting in using local buildings for community purposes. The officers were to work closely with the two Community Care assistants at the Council of Social Service over this. There were some months of discussion over the job descriptions, local Social Services Managers still fearing that the officers might inappropriately undertake Social Work tasks, and housing department representatives wishing to carry more emphasis on the warden duties of the posts. The jobs were finally advertised in February 1979 and the first worker was in post in Shirley Area Office in July 1979, the second at Woolston in November 1979. Both those appointed were previously employed by the Housing Department in other capacities.

Problem Areas

All the managers agreed that in the early days of the project there were areas of difficulty which made for stormy meetings of the Steering Group. This Group consisted of the Organising Secretary of the Council of Social Services, the Principal Area Officer from Shirley Social Services Office and the Assistant Principal, the Principal Area Officer from Woolston and the Assistant Principal and three representatives from Housing; the Deputy Head, the Head of the Management Section and the officer responsible for the elderly and for wardens. The problems lay in two distinct but linked areas. How was each worker to divide her time between the two major agencies and how was she to divide her time between the functions she was expected to carry out? The solution that individual workers chose to these problems reflected their personalities, their past experience and the pressure exerted by the managers. Each contracting organisation has a different emphasis and each would prefer the worker to put its own tasks first, while recognising that some time must be spent on other functions.

The Shirley worker never became well integrated in her Social Services base. The social worker at that base who had the responsibility for assisting this process of integration did not pursue the task with much enthusiasm (comment of Assistant Principal Area Officer, 11.9.81). The Shirley office, which had a highly developed professional ethos,

still remained suspicious that the Visiting Officer might attempt to undertake social work tasks. At the Steering Committee of 30th November 1979 the Principal Area Officer reported that there had been no personal contact by the Visiting Officer with any social workers in Shirley for the past two months. Problems were again reported in February 1980 and this led to a suggestion from the Organising Secretary of the Council of Social Service that there should be individual supervision groups for the two workers and that the overall Steering Group should consider policy matters and meet less frequently. A pattern emerged of supervisory groups meeting every six weeks and the Steering Group every six months. The difficulties in Shirley were not immediately resolved and at the meeting on 2nd May 1980 it was reported that the worker had resigned but that the Social Services representatives had not known of this until the advertisement for her replacement appeared. Her successor, appointed in July 1980, also came from the Housing Department but she had undergone social work training previously. This made her much more acceptable to her Social Services base (comment of Assistant Principal Area Officer, 11.9.81). It was formally agreed that she should spend one day a week in the Housing Department and the rest of her time in the Shirley Area Office or out in the community.

The tasks of the post fall into the three areas of individual referrals, surveys and community development work. A meeting of the Steering Group on 29th October 1980 agreed that each of these areas should take up one third of the worker's time. The Shirley worker reports that referrals take about half her time, leaving half for surveys and community development. The Woolston worker had a housing department background but had had considerable involvement while there with the Health Service and the content of her work in this post reflected that. She undertook a great deal of liaison with the Health Services for the frail and mentally ill elderly, and she was more in tune with the predominantly welfare ethos of her Social Services base than was the first appointment in Shirley with the more professionalised attitudes of her base. The work in the community development field requires liaison with the Community Care Officers employed by the Council of Community Service who have a more ready access to community transport and networks. As the initial impetus for the post arose in the Housing Department, the Housing Department Managers tend to value the task of

visiting the elderly in non-warden controlled housing more highly than other managers in the scheme. The Organising Secretary of the Council for Community Service sees himself as holding the ring between the two statutory bodies in areas of difficulty.

Discussion

All the managers agreed that, apart from the individual achievements of the workers, such as the establishment of clubs for the elderly in Coxford and Weston, there had been a general improvement in collaboration between the three organisations. By this they meant a greater understanding of the ways of working of each organisation by the others and a greater readiness to work together on common problems. Such an improvement is hard to quantify and to evaluate and this is a common difficulty with joint finance schemes. Collaborative schemes may have concrete and tangible benefits for clients/patients, but also intangible benefits in the shape of improved working relationships for staff which of course, also improve patient care. The objective of developing greater liaison between the Housing Department and Social Services Area Centres was thus met. The Community Development Schemes, such as the clubs for the elderly, met the objective of stimulating voluntary care within the community. The Shirley worker spent much of her time fulfilling this objective. Whether the aim of more effective use of housing stock was achieved is harder to say. No exercise was carried out by either department to demonstrate this. The major disagreements over the use of worker time had been resolved by the end of 1981 and at that time the main issues before the Steering Group were:- What is the appropriate training for this worker, how to extend the work to other areas of the city and the possibility of regrading the post from AP2 to AP3 because of the amount of individual initiative required from the workers.

Some problems did arise because the scheme was originally promoted by the Director of Housing and the Assistant Director of Social Services, rather than emerging from fieldwork staff. This "top-down" approach probably made it harder for those implementing the scheme to come to a common understanding at first and produced much more administrative work. On the other hand it also meant that resources were more easily available for the scheme. The Organising Secretary of the Council of Community Service commented that joint finance is a more neutral

source of finance than either the Social Services Committee or the Southampton Policy and Resources Committee which funds the Council for Community Service, because joint finance is not under the sole control of any one agency. In relation to this particular scheme, joint finance did encourage an innovation which would be unlikely to have occurred otherwise at that particular time. Here again, as indicated in Chapter III, financial constraints are an important variable in innovation.

b) The "Living, Working and Dying" Course

This joint training project arose from collaboration between medical, administrative and nursing staff in the Southampton Health District, and managers, training officer and social workers in the South-west division of Hampshire Social Services department. The methodology of this case study was described in Chapter I.

Training for those working in the Health Services had remained on the whole very separate from that for those working in the personal Social Services until the mid-1970's, reflecting the different historical development of the professions within the two services. Medical and nursing training were much more firmly established, and entry into the statutory professional registers was limited to those qualifying at the end of a period of training. Social work training had only really begun to expand in the 1950s and even now social workers are not statutorily required to undertake a period of training or obtain any qualification before being employed as social workers. However the changing needs of clients and patients, described in Chapter II, generated a recognition that more integrated systems of care were required particularly for the elderly and mentally and physically handicapped. The Working Party on Collaboration (DHSS 1974) took the view that joint training would aid the collaboration needed to provide such integrated systems of care by promoting better understanding and knowledge of the services provided by complementary services, and this view was echoed by Webb (1978) in his study for the Personal Social Services Council and by the Royal Commission on the National Health Service (Cmnd 7615). It was suggested in Chapter III that separate training might accentuate difference between services which already differ in philosophy and types of staff recruited. This case study offered a

chance to examine this particular facet of collaboration.

Joint Training in Hampshire

Local approval for the use of joint finance for joint training followed the JCPT recommendation on 28th February 1978 that 2½% of the total allocation should be reserved for inter-disciplinary training activities. For the year 1978/9 that was a sum of £17,500. However, it was not until 5th December 1978 that a discussion paper was presented to the JCPT by an officer from the Corporate Planning Department setting out some criteria for the use of this money. This paper was circulated to District Councils, Health Districts, Social Services Divisions and Area Education Offices, and was finally discussed with their comments at the JCPT of 22nd May 1979.

The paper comments "There is a danger that joint funding (sic) will simply be used to reinforce each services own courses unless some thought is given....to ways in which joint training might be encouraged in future years". It points out that "joint training is one method of encouraging a coherent and co-ordinated approach by different services to the same problem, or client group", and it discusses both the categories of staff that might benefit and the various ways that courses could be organised. It recommends building on existing structures within health and social services and suggests that outside bodies such as universities, the provincial councils and voluntary bodies should be informed that joint finance was available for inter-disciplinary courses. These recommendations were supported by the JCPT and among the topics suggested for future courses was "grief and loss" (JCPT minutes 22nd May 1979).

In April 1980 a further paper was produced, this time by the Health Services Liaison Officer on "The Use of Joint Finance Monies in Support of Training" which discussed difficulties that had arisen and proposed revised administrative procedures. This was on the JCPT Agenda on 10th June 1980 but pressure of business prevented it being discussed. The JFE on 12th June 1980 agreed that it should be regarded as for information for the JCPT and that the approval of the JCPT Chairman should be sought for the revised procedures, so that implementation would not be delayed. This second paper sets out two broad areas for joint training:-

"(i) the development of skills which can be applied in different settings.

(ii) the acquisition of knowledge and experience which can be integrated into specialised learning".

It discusses some of the difficulties in setting up joint training schemes. Training is organised differently in health and social services and "opposite numbers" for training do not exist. Training within the Health Service is more integrated in the treatment settings, controlled by professionals and more developed at a post-qualifying level than in the Social Services. The original joint finance allocation for training to the Social Services Department was equal in size in each Division to its normal training budget. More staff time, which could not be made available because of manpower restrictions, was needed to absorb this. (In fact the joint finance allocation for training was reduced in December 1979 to £15,000 per annum for this very reason and it remained at this level through the remainder of the period of study). HSLO commented (interview 23rd May 1980) that too much money had been available too soon - more understanding was necessary of how people learn. Finally, the paper sets out the criteria for use of the money. Courses should follow the general aims of joint planning and the client groups should be those given priority by the JCPT. Courses with elements of joint planning and joint participation would be preferred. Details are then given of the administration of the allocation for training and revised methods of payment.

The Planning of the "Living, Working and Dying" Course

This course was planned in the summer and autumn of 1979 and took place from January to April 1980 - that is before the appearance of the second JCPT paper on training. However, it met many of the criteria of that paper. It was jointly planned with joint participation and it could be said to be directed at all the JCPT priority client groups. It attempted to provide "a coherent and co-ordinated approach by the different services to the same problem" as recommended by the first JCPT paper and it followed the suggestion made at the discussion on that paper that grief and loss would be a useful topic for joint training.

The idea for the course germinated in two different settings. The Hospital Social Workers in the South-West Division, organised in a General Health Team, had discussed with the Assistant Principal

Officer for Health in that team the possibility of a study day on loss and bereavement. In the newly established Oncology Department at the Royal South Hants Hospital the nurses, chaplain and social worker felt unsupported by the medical staff in their attempts to cope with their feelings about caring for their seriously ill patients, many of whom were young. This concern was picked up by the Administrator of the Wessex Regional Cancer Organisation, a Regional Health Authority body based at the Royal South Hants Hospital with links with those working in the field of cancer in different capacities throughout Hampshire. The Social Worker in the Oncology Department was also a member of the South West Division General Health Team and through her each group heard about the other's concerns. The General Health Team wanted a study day while the Oncology Department and the Administrator of Wessex Regional Cancer Organisation were looking for some sort of support group. At first these two ideas seemed too disparate but the groups were drawn together because neither had sufficient funds in their training budgets to fund a project of any scale. Joint finance training monies would be available to both if, but only if, they co-operated in a training project. A joint project was "cobbled together" in the words of the Administrator of Wessex Regional Cancer Organisation and it was the existence of joint finance which brought and kept them together.

A planning group was set up on the Health side consisting of the Administrator, the Ward Sister of the Oncology Ward, the Consultant from the local Continuing Care Unit, the Divisional Nursing Officer of Southampton Health District and the Clinical Trials and Information Officer from Wessex Regional Cancer Organisation. This last acted as administrative officer and the Divisional Nursing Officer only played a minor role. Social Services representatives were the Principal Area Officer (Health) for the South West Division, her Assistant Principal Officer, the Training Officer and the Oncology Social Worker. This Social Worker felt that her managers were uneasy at her presence on the planning group, perhaps because of other difficulties that there were between them at the time and that they were relieved when she left the Department and also the planning group in July 1979.

There was general agreement that the course should cover the area of caring for the dying, but after that each side wished to emphasise different aspects, and handle the material in different ways. These

differences reflected the different needs that had produced the two different proposals that were "cobbled together". The Health side and the Oncology Social Worker sought a course with a therapeutic element which would offer support for staff working with the terminally ill. The social work side wanted lectures and discussion groups which focussed on the lecture material, although the Training Officer pressed also for some experiential sessions. Eventually the format of ten lectures, followed by discussion groups, was decided upon. However, the advice of a Consultant Psychotherapist was sought over the choice of leaders for the discussion groups and she suggested individuals who had experience in therapeutic groups. The Principal Officer (Health) felt that the health representatives - five in all - also had much more influence on the choice of lecturers, as the health side had more experience in presenting courses for large audiences. However, the Consultant from the Continuing Care Unit thought that the Social Services representatives - four initially, three after July 1979 - dominated the planning group and he felt particularly wary of the Training Officer. The Assistant Principal Officer (Health) also saw the Training Officer as the odd one out but felt that, out of departmental loyalty, he sometimes had to conceal his disagreements with him. Thus, although the joint finance money had brought the two groups together, Health and Social Services still tended to split into sub-groups within the main group. Those who were more ready to recognise the validity of the ideas of the other sub-group felt uncomfortable and either left, like the Oncology Social Worker, or suppressed their feelings, like the Assistant Principal. It is not unexpected, however, that at the beginning of a co-operative venture, two different sides will be wary of each other, and this point will be dealt with in more detail in the discussion in the final chapter.

An application was made for an allocation from the 1979-80 joint finance budget and, when it was successful, the need to spend the money before the end of the financial year in April 1980 telescoped discussion. The ten lectures and their associated discussion groups were held between January and April 1980. The programme is shown in Appendix 5. The course was over-subscribed. There were sixty-six applicants - the maximum expected was fifty - and a further discussion group had to be set up. The majority of the applicants were nurses or social workers. Only three were doctors. Participants came from an area stretching

from Basingstoke through Southampton to Poole and Weymouth in Dorset.

Discussion

The course had successful and unsuccessful aspects and demonstrated some useful lessons about joint training. Course participants completed an evaluation sheet at the end. They rated most of the lectures as good but there was much less enthusiasm for the discussion groups and only one was rated uniformly successful by its members. This group continued to meet for several months after the end of the course - a tribute to its experienced and skilful leader. The other groups veered uneasily between therapy and discussion and did not meet the diverse needs of their members.

The lack of doctors as participants was a major deficiency in any group learning about caring for the dying. The few who attended had to listen to much hostility expressed about the care that doctors in general offer the dying and none stayed the course. The Consultant in Continuing Care felt this demonstrated that doctors are still so insecure when faced with a non-medical viewpoint that they need a group of their own where they could feel sufficiently safe to discuss these issues first. He subsequently set up such a group. It might be argued that this is the antithesis of collaboration but what it really illustrates is a more realistic appreciation of the difficulties of collaboration because of the different frames of reference and stages of development of the professions involved in Health and Social Services described in Chapter III. The problems the doctors met in relation to this course show that much preparatory work may need to be done before useful collaboration can occur. It is not sufficient simply to mandate organisations or individuals to co-operate. Nor is the goal of joint training suggested by the Working Party on Collaboration, the goal of better understanding and knowledge of the services provided by complementary services, quite so easy of attainment. However only a real understanding of the problem has the potential to produce genuine advances in collaboration. The fact that nurses and social workers were able more successfully to come together and share experiences and learning did mean that the course brought about an overall increase in collaboration and understanding. Nurse and social work trainers have collaborated on further courses and built on the experience gained.

TABLE II. Innovation and Joint Finance in Hampshire 1976-1982

Care Group	Number of schemes per Care Group	Number of innovatory schemes per Care Group (% in brackets)	Total allocation to Care Group	Total spent on innovatory schemes per Care Group (% of total in brackets)
Mentally Handicapped	28	4 (14.2%)	£1,502,178	£224, 987 (14.9%)
Elderly	59	9 (15.25%)	£1,637,263	£185,900 (11.35%)
Physically Handicapped	23	12 (52%)	£1,415,110	£382,879 (27%)
Children	7	3 (42.8%)	£179,149	£160,880 (89.9%)
Mentally Ill	16	8 (50%)	£179,613	£149,606 (83.2%)
Other (including Primary Health Care - counted as 2 schemes)	36	10 (27.7%)	£1,256,771	£116,743 (9.28%)
TOTAL	169	46 (27.2%)	£6,170,084 (excluding inflation uprating)	£1,220,995 (19.78%)

Other members of the planning group felt they learnt useful lessons about joint training. The Assistant Principal identified in particular the need to be clear about the objectives of all participants. The Administrator of the Wessex Regional Cancer Organisation saw it as the first attempt on the health side to run a course which changed attitudes and looked at feelings rather than teach skills. The course did not lead directly to the establishment of support groups for staff in the Oncology Ward but such a group of nurses and chaplain does now meet. In all, the course could be said to have provided a co-ordinated but not fully coherent attempt to offer training in caring for the terminally ill.

c) Evaluation of the Case Studies

Although both case studies were of innovatory joint financed projects, only a minority of joint finance schemes in Hampshire were innovatory, rather than extensions or underwriting of existing schemes which were otherwise threatened with curtailment due to economic restrictions. This is true whether number of schemes or money allocated to innovatory schemes is the measure of innovation. Table II gives both numbers of innovative schemes and money allocated to them. It expresses both innovatory schemes as a percentage of the total number of schemes, and money allocated to innovatory schemes as a percentage of the total joint finance allocation to 31.3.82. 27.2% of joint finance schemes in Hampshire were innovatory and the money spent on them represented 19.78% of the total allocation, excluding inflation uprating. The implications of spending on innovation as a proportion of the total allocation will be discussed in the final chapter.

Both schemes studies fostered multidisciplinary collaboration. The training course involved officers from separate agencies working together on a project, the Housing Visitors' Scheme had one worker providing a service on behalf of two separate agencies. The main actors in both schemes had had past contacts with each other in the normal course of their work, but these schemes required that they work much more closely because no one service controlled the resources or the operation. The Housing Visitors Scheme was the one where the problems of collaboration were resolved most successfully, and it seems probable that this was because the actors had a longer period in which they

could learn about another service's ways of working and frames of reference and develop some common objectives. With goodwill this could help to overcome the difficulties. However, the actors in the training scheme also learnt valuable lessons about collaboration - even if, in the case of the doctors, it was that unless there is a common outlook or common objectives, preliminary work is needed before collaboration can be successful.

The ideas that produced the schemes were generated in a variety of places. The Housing Visitors' Scheme was a "top-down" innovation, whereas the training course arose from needs expressed at operational level. However, the managers of the services involved in the training scheme took on the task of organising the course and obtaining resources for it. The participation of the operational level in the shape of the Oncology Social Worker was limited to the early stages of planning, although the consultant from the Continuing Care Unit could be said to represent both operational and managerial levels. In an on-going project like the Housing Visitors' Scheme the shape of the scheme becomes a product of the inter-action between the field workers and, in this case, the Steering Group. It becomes difficult to assess at what point the product of the inter-action is more important than that of the original impetus. It was suggested earlier in this chapter that the "top-down" nature of this innovation had both advantages and disadvantages. The organisational problems of joint training, described in the second paper on training for the JCPT in June 1980, were apparent in the "Living, Working and Dying Course". The uneasy mix of operational and managerial levels, professionals and administrators, was due to the lack of opposite numbers for training in health and social services, and the different location of training responsibilities in each service.

Financial matters certainly affected these two projects and the way in which they were implemented, as postulated in Chapter III. The existence of the joint finance scheme both liberated and constrained these projects. Neither could have come into operation without joint finance at that time, because of the resource constraints in normal budgets. However, the limitation of having to spend the allocation inside the financial year and the consequent short period for planning may have contributed to the failure to resolve entirely the difference in approach of Health and Social Services to the training course. The

fact that the Social Services Department had to take up the revenue cost of the Housing Visitors' Scheme after five years probably meant that the scheme could not be started in other areas of Southampton, as the Housing Department might have wished, because Social Services would not commit any more resources to this.

What these two case studies do demonstrate is the flexibility of joint finance. This flexibility might seem perilously close sometimes to special pleading as in ADSS's advocacy of schemes for the Stonham Housing Association, but the lack of definition in the 1977 circular does permit a very wide interpretation.

> "The criterion by which an AHA will use the money allocated to it by joint financing will be that the spending is in the interest of the NHS as well as the local authority and can be expected to make a better contribution in terms of total care than if applied directly to health services". (DHSS HC (77) 17).

This leaves a wide arena open to the collaborating authorities. With the agreement of the Health District and the AHA, the Housing Department of Southampton was able to tap joint finance funds, although the advantage to the Health Service was rather distant. Joint training is not mentioned by either Lauerman (1980) or Norton and Rogers (1981) in their lists of joint financed schemes, but in Hampshire joint finance is earmarked for joint training projects. Although there will always be a number of reasons for a particular innovation occurring at a particular time, joint finance was certainly an important factor in ensuring that these two innovative ideas were implemented.

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CHAPTER VI. CONCLUSIONS

This study set out to examine the working of the joint finance scheme in Hampshire from 1976 to 1982, and to evaluate the effectiveness of the scheme in promoting an increase in collaboration between health and social services authorities, and in aiding innovatory ways of working. To do this it was necessary to define and operationalise the concepts of collaboration and innovation. Collaboration was defined as an activity which may embrace any or all of sharing of services, co-ordination of service delivery, joint planning and joint prevention carried out by two or more administratively separate agencies which is directed towards providing an appropriate combination of health and social care for its recipients, and which will be modified by attitudinal and structural factors in the collaborative environment. Innovation was defined as a process of introducing a new service, or a new way of organising a service already existing, in the area of study. The operation of the joint finance scheme in Hampshire was then examined in the light of these two concepts. In this chapter an attempt will be made to evaluate the effectiveness of the scheme in Hampshire.

Expectations of the Scheme

The original expectations of what the scheme might achieve will inevitably influence any rating of effectiveness. The Consultative Document "Priorities for Health and Personal Social Services in England and Wales" (DHSS 1976), which set the tone for inter-service collaboration and planning in the latter part of the 1970s, suggested that if joint finance proposals under discussion at that time became concrete, joint finance should be used to secure an improvement in community based services for the priority care groups and to aid joint planning. Booth (1981b) sets out four main aims:- first, switching resources from long-stay hospital services into the community; second, providing a stimulus to joint planning by offering a financial incentive; third, to smooth over conflicts between health and social services occurring when their responsibilities overlap, as in care for the elderly; fourth, to promote innovation and experiment in service delivery. There is open acknowledgment of these first, second and fourth aims in DHSS HC (77) 17, although the third aim is hinted at rather than spelt out. However, David Townsend, speaking at the 1978 Disability Alliance Conference in his official capacity as Special Adviser to the DHSS, did

sound a note of caution. He suggested that joint finance was not a sufficiently large sum to achieve a huge shift in emphasis in service provision on a national scale. Only shifts at the margin could be expected. He emphasised its use in adapting existing programmes or setting up experimental projects. These three sources - the Priorities document, the 1977 circular and the speech of the Special Adviser - give some indication of official central government expectations of the scheme. David Townsend's speech tones down the broader aspirations of the Priorities document and the 1977 circular, but what these official pronouncements show is how broadly the scheme could be interpreted and how flexibly it could be used. This is borne out by the working of the scheme in Hampshire, and shown particularly in the case studies described in Chapter V.

In Chapter II the mixed reception given to the scheme was described and the emphasis put on the scheme by politicians who, at the time of its introduction were reducing the resources available to the personal social services in general, because of the economic crisis. The idea of joint finance being used for innovation and experiment became popular, and sometimes seemed to be the dominant expectation in relation to its use. An administrator from Devon AHA speaking at the 1978 Disability Alliance Conference emphasised the chance joint finance gave for experiment. Lauerman in his research is critical of the authorities he studied for spending so little joint finance on imaginative and innovative schemes. Councillor Samuels at the Hampshire Social Services Committee meeting on 18.7.80 expressed the view that joint finance was primarily for innovation and experiment. Another councillor agreed and no one contradicted them. Joint finance was also popularly seen as an aid to communication between health and social services departments. As Gwen Swire, Head of Social Work for Salford Social Services, commented at the 1978 Disability Alliance Conference "Joint Funding (sic) has forced us to start talking together".

However it became clear that devising innovative schemes required more staff time and highlighted more problems than did spending joint finance on extending or underwriting existing schemes. The examination of the two projects in Chapter V demonstrates this in Hampshire. It was therefore naive to expect that joint finance would be spent predominantly on experimental schemes. Collaboration was an ideal that

everyone subscribed to, but in practice the differences between the collaborating authorities in philosophy, style, structure, finance and accountability raised problems which might be glossed over or ignored in existing schemes but had to be grappled with in new ventures. The difficulties with the doctors in the training course, and the different expectations of the housing department and the social services department in the Housing Visitors scheme are examples of this.

Learning to Collaborate

It became increasingly evident to the author during the course of the research that because of these difficulties of collaboration between independent authorities, people need to learn to collaborate and they need time for this learning. Only Wistow of those who have studied this area mentions this. He suggests "the time scale within which social learning takes place may be somewhat longer than originally appreciated". (Wistow 1982). It was helpful to collaboration during the period of study in Hampshire that the JFE had for most of that period a relatively stable membership and that among those members were officers with considerable influence in their respective authorities. One health administrator who acted as secretary of the group for some time admitted that his perspectives had been widened considerably by participation in collaborative activity. He now had a much improved understanding of the working of District Councils and the use that could be made of the Chief Housing Officers Group, comprising the Chief Housing Officers of those Councils (interview 7.10.81). He had had no reason to contact this Group before the introduction of joint finance. The general tenor of the JFE was that of a group working together to resolve problems rather than one where individuals or groups took refuge in well-defended positions. This made it probably one of the most successful formal collaborative groups in the area studied and it offered both a model for the way other groups might behave and a good experience of collaboration which those involved in it could carry elsewhere. The comparison between the two case studies in Chapter V showed that one factor in the greater success of the Housing Visitor's Scheme was the longer time period available to overcome the problems of collaboration. The general expectation of central government that it was sufficient first to mandate collaboration, as at the 1974 reorganisation,

and then to offer extra financial incentives was a naive one. However it is true that the financial carrot did produce a defined area within which officers and members could learn to work together.

The Importance of Personality

It is a much debated issue among professionals and administrators whether the organisational structure or the personalities who staff it carry more weight in determining how a particular system operates. Etzioni (1961) in discussing compliance and organisational elites draws up a typology of elites thus:-

	Power derived from office	
Personal Power	+	-
+	Formal leaders	Informal leaders
-	Officers	Non Elite

He distinguishes between the instrumental needs of an organisation - that is, those relating to input and allocation, and the expressive needs - those relating to social and normative integration. He suggests that organisations develop different action systems to fulfil each set of needs because incompatible role orientations and psychological characteristics are required by each set. Officers are most likely to control instrumental activities. The collaborative structures examined in this study fall largely into the area of instrumental activities, involving officers rather than members, but even within this area it was apparent that in addition to the power they derived from office, some officers wielded personal power which could be said to mark them out as informal leaders in collaboration. The Royal Commission on the NHS which reported in 1979 was clear that personalities rather than structure dominated.

> "If there is determination on both sides to work together, many of the problems ..... would be solved. If authorities or professions are at loggerheads, coterminous boundaries, overlapping membership and joint committees will be ineffective. Post re-organisation experience shows that effective collaboration requires that those involved should have appropriate training and sufficient authority within their own

(cont'd...)

> organisation to carry out the task which is to be performed jointly. Continuity in post of the personnel involved is particularly important". (Cmnd 7615).

If such continuity is a vital factor, and it seems to be if there is to be time for learning to collaborate, the 1982 NHS reorganisation with its upheavals for staff will be likely to reduce collaboration, just as Wistow and Webb feared for other reasons (Wistow and Webb 1980).

In Hampshire there were people in the collaborative arena who owed their entry into it to their senior positions in their respective authorities but whose dominating influence in the joint finance sphere was due to personality characteristics. ADSS was one such personality. Described by one officer of a voluntary body as "the paymaster of joint finance" he took an active and pragmatic role in fostering collaboration both in and outside the JFE, and was always seeking ways in which joint finance could be used to extend or support services. His position in the Social Services Department gave him considerable authority but he used it to the maximum. His good working relationship with LCP, who, by virtue of his role as liaison between health and social services on behalf of the AHA, had widespread links in both services, produced useful and effective collaboration. Here the quieter, more compromise-seeking personality of LCP was a good counterpart to the more forceful ADSS.

Another dominating figure was DCP from Southampton. Although his office only gave him power technically within his own Health District and in formal relationships between it and other bodies, his intellectual ability and forceful personality meant that he was a dominant contributor to collaborative meetings, and his opinion was heeded on matters outside his own sphere. HSLO on the other hand suffered from both a weak position in the structure of her organisation - she was not on the Senior Management Team of the Social Services Department - and from being overshadowed by the personality of ADSS. Rowbottom and Hey (1978) and Webb (1978) have both commented on the difficulties of the post of HSLO in general, and the fact that the post disappeared in Hampshire in the Social Services reorganisation of 1981 suggests that the office itself was not valued. However the structural problems in Hampshire were certainly compounded for HSLO by the activity of the organisationally more powerful ADSS in taking over so much of her potential role because of his interest

in obtaining resources for the Social Services Department from all available sources.

No member, either of the AHA or of the County Council, had a particular interest in collaboration. County Councillor Samuels made comments about it regularly at meetings but he was equally vocal on other subjects. He had the impression that joint finance was principally for primary health care (interview 26.2.81) and felt ambivalent about co-operation. An AHA member (interview 22.2.82) commented that the AHA merely rubber-stamped joint finance and decisions made by the JCC had all been agreed before the actual meetings between the officers and chairman of the different authorities. Individual members had very little influence. The Chairman of the Social Services Committee, who also sat on the AHA, commented how much more rewarding County Council membership was, in terms of decision-making. (Interview 3.3.82). He saw personalities as more important than structures in producing action in the collaborative area.

Booth (1981a) takes the view that neither structure nor personalities are sufficient. However appropriate these are, events external to the collaborative process can, as suggested earlier in this study. skew the local operation of the system. Moreover, as Booth (1981a) suggests what may benefit the whole community may be bad for a specific authority. This echoes the comments of ATb in Hampshire (interview 16.9.81) that collaboration would improve if Health Districts felt there was more specific advantage to them. Organisations, even those which have originated to serve the public, or certain sections of it, develop organisational needs and the good of the community is not sufficient reason for a particular course of action. As Merton (1968) observes

> "the esprit de corps and informal social organisation which typically develops in such (bureaucratic) situations often leads the personnel to defend their entrenched interests rather than to assist their clientele".

Effectiveness of the Joint Finance Scheme in Promoting Collaboration in Hampshire

It had always been possible for health and local authorities to fund jointly out of their normal budgets schemes which were of interest to both of them. On the whole this occurred rather seldom in Hampshire

before 1974. The development of Kinloss Court Special Housing in Southampton as a joint scheme by health, social services and housing authorities was a notable exception. The introduction of the joint finance scheme certainly secured a vast increase in the number of collaborative schemes in the county. Officers were ready to acknowledge that co-operation had increased since 1974 (Health administrator interview 26.9.80) and that joint finance kept the links going (Health administrator interview 7.10.81). The District Community Physician from Southampton felt that the priorities of health and social services were more similar now (interview 17.9.80). Collaboration at operational level was certainly greater.

However there were criticisms. Wright (1982) showed that joint planning for the elderly mentally infirm in a large part of the area studied had not been successful and this comment can be extended to joint planning in Hampshire generally. The reasons for this have already been mentioned - the differences in planning styles and systems, the different objectives for each service in collaboration - and the other studies of collaboration discussed in Chapter I also found that joint planning had failed. The County Council's representative from the Treasurer's Department on the JFE commented "you might as well give the money to the local authority unless you joint plan". Treasurers' representative from both health and local authority on the JFE were also particularly critical of the lack of monitoring and evaluation of money spent under the scheme. The representative from the AHA felt that any evaluation of effectiveness of the money spent was subjective (interview 16.9.81), and the representative from the County Council that there was insufficient consideration of alternative ways of spending the allocation (interview 24.3.82). It sometimes seemed as if it was so difficult to spend the allocation because of the limitations imposed by the structure of the scheme and the economic difficulties which brought resource restraint and manpower limitations, that officers breathed a sigh of relief when a scheme met the criteria, allocated the money and thought little more about it. Only when a particular project came back to ask for an increase in their grant or a further allocation, were questions of monitoring considered.

What joint finance did provide was an increased impetus to work out schemes which could be jointly funded from normal budgets and this

may be one of its most valuable contributions to collaboration in Hampshire in the period studied. The Care Attendant Schemes offering care to the severely disabled in their own homes, operating in all three Social Services Divisions and all four Health Districts by the end of the period of study, are the best example of this. They have been fully described and assessed by Lovelock (1981). As suggested in Chapter V, their success as a pilot scheme made it difficult not to continue the service once joint finance ceased, and the county council and respective health districts agreed to continue funding from normal budgets on a 50/50 basis. Discussions were proceeding in 1982 to extend the schemes to other areas of the county. It is very unlikely that such a major new service for the physically handicapped would have come into being in a period of resource restraint without joint finance. The NAHA study shows other authorities in the country are pursuing this option of joint funding too. (Wistow and Head 1981). A small pilot scheme for Care Attendants working with the elderly was tried in the Petersfield area of Hampshire on the same basis as the joint financed schemes for the physically disabled. When the results of this are known, it is possible that this too will result in more integrated schemes of care for the elderly being set up. The flexibility of the scheme was a definite asset. The fact that it was not tied to traditional spending heads in social services budgets, that it could be used for capital or revenue schemes and for one-off or recurring revenue schemes made it of great use to pragmatic managers like ADSS or DCP. HDA described joint finance as like a charitable trust, flexible enough to provide a sum of money to stimulate, or to preserve something that might otherwise be brushed away. Was full use made of this flexibility in Hampshire?

Tidball (1981) suggests that many local authorities and AHAs have not exploited joint finance to its fullest extent. His lively article questions some assumptions and practices that have grown up around joint finance. Although he agrees that innovation is important "it seems by no means clear that joint financing is the ideal risk or venture capital", and he suggests that consolidation and improvement of services should not be regretted as targets for joint finance. He discounts the view that joint finance distorts joint planning. The reality is tthat a number of factors intervene in local government finance to prevent

plans being implemented exactly as wished and this has to be accepted as a fact of life. Some authorities have tended to expect that the same source of funds should be used throughout a project's life. It might be more appropriate to use funds from different sources at different times - joint finance could be used for capital works and other resources used for staffing costs at a later date. Most importantly Tidball points out that DHSS circular HC (79) 18: LAC (79) 11 gave authorities the opportunity to extend joint finance schemes for a further seven year period if they agree that circumstances are exceptional. This was to give authorities some help in the climate of uncertainty over resources in which they were operating, and did give considerable assurance of certainty in this situation. In Hampshire although joint finance was used very flexibly as regards types of scheme and balance of capital and revenue, it was not exploited in the way suggested by Tidball to create an almost indefinite source of finance for any particular project.

Of all the aspects of the concepts of collaboration and innovation described in Chapter III it was that of availability of resources which dominated those who tried to implement the joint finance scheme and it must therefore be an important consideration in any assessment of its effectiveness. In earlier chapters it was described how its introduction at a time of economic retrenchment made it welcome as an extra source of finance but that the rules of the scheme, particularly in relation to take-up, were a severe limitation on its use. This limitation must have prevented the consideration of a number of schemes in Hampshire which would have been acceptable on all other grounds. It is interesting to note that Wistow and Head's respondents report increasing restrictions being placed upon the use of joint finance for revenue schemes by local authorities yet returns to the DHSS show an increased proportion of joint finance being spent on revenue schemes - 53% in 1978/9, an estimated 61% in 1980/1. (Wistow and Head 1981). The authors speculate that the national returns may reflect a shift from long-term revenue schemes to short term schemes and non-recurring revenue items. Table I showed that in Hampshire during the period of study only 36% of schemes were recurring revenue schemes. The individual case studies too demonstrated the importance of resource availability and the way in which those resources were made available. Joint finance made schemes possible that would not otherwise have come into being, like the training course and the Housing Visitors' Scheme, but

its limitations constrained them too.

However, the author's study in Hampshire bears out the conclusions of both Booth and the Loughborough study - that joint finance has been responsible for most of the practical achievements in the field of collaboration, although so far it has only laid some foundations for joint planning. In contrast to the other areas described by the other studies, Hampshire does seem to have been reasonably innovative in its use of joint finance, and the support for joint training is particularly interesting here. That particular use of the money threw into relief - notably in the training course described in Chapter V - the differences in attitude which staff attempting to collaborate may have, and the need for time to learn to collaborate. Although some of the expectations for joint finance were naive and misguided, it is evident from the very limited collaboration that was in operation before 1976 in Hampshire that it was responsible in the area under study for promoting an increase in the amount of collaborative working. Perhaps, though, it is important to be clear that "one cannot know what would have happened if a service had not been provided, one can only make informed guesses". (Bristow 1980).

Future Organisation for Joint Finance

The 1982 NHS reorganisation cast its shadow as far back as July 1979 when plans to devolve some responsibility for joint finance decisions to Health Districts and Social Services Divisions were shelved because of it. The expanded JFE was another foretaste. ADSS was very concerned that the collaboration and expertise developed at the JFE should be retained in the new system and this was a theme to which this officer often returned at the JFE and elsewhere during the build-up to reorganisation. The major decision to be made was whether joint finance allocations to the four independent District Health Authorities wholly within the administrative county should be pooled and administered on a county-wide basis, or whether each DHA should allocate independently. The County Council was obviously in favour of a pooling as it would find difficulty in servicing four different allocation meetings and it feared that attempts to plan collaboratively on a county-wide basis would be vitiated by four individual DHAs allocating funds. The DHAs on the other hand, might fear that the needs of their Authority might be

subordinated to those of the County Council or those of more vocal DHAs, if allocation was pooled.

At the JCC of 24.5.82 the new arrangements were agreed. For a trial period of one year a consortium approach would be operated. Allocations to individual DHAs were to be pooled and administered by Basingstoke and North Hampshire DHA acting as agent for the three other DHAs. It was hoped that joint finance monies relevant to the overlap areas of Surrey and Wiltshire DHAs would be added to the pool but negotiations were still proceeding. The JFE would continue to function as it had done since September 1981 when it expanded its membership, and the role of the JCPT and the JCC would continue virtually unchanged in relation to joint finance. To meet some of the criticisms that allocation of joint finance was slow because of the number of approvals needed for its disbursement, the JCPT was discussing wider powers for the JFE within an agreed financial limit to approve certain applications. This was to be the subject of a formal proposal to the JCC in due course. At this JCC meeting the Chairman of Portsmouth DHA gave notice that his Authority might wish to withdrawn from the consortium after the trial period. They would wish to use joint finance for longterm planning and would not want to compete with other DHAs for their share. In April 1983 Portsmouth DHA did withdraw from the consortium and Basingstoke followed suit. New arrangements for joint finance applications, largely District Health Authority based, are now in being. A paper presented to the new JCC by the new JCPT made a start in meeting the oft-voiced criticism that there had been no joint planning, only joint spending of joint finance. (Wright 1982). The paper set out the two stages necessary: first, basic information about services existing by care group: second, evaluation of that information and a response to it. As an appendix members were supplied with a table setting out by care group the residential and community provision available in the county as a whole provided by the health and social services and the voluntary sector, and with a scheme for assembling information appropriate to joint planning. This could be a sign that a more structured approach may now be taken by the officers to the use of joint finance, despite the problems outlined earlier in the chapter.

To set against this more positive approach there is the disappearance of HSLO and the change in position for LCP. Since the end of 1981 HSLO's

functions appeared to be shared between the ADSS (now Senior Assistant Director), one of the other Assistant Directors and the Principal Officers (Health) based in Southampton, Portsmouth and Winchester. ADSS took over most of HSLO's role at the JFE but an Assistant Director joined the JFE in January 1981 to supply the professional social work input. With the end of the AHA, LCP lost his county-wide position. There was some speculation that his post might become one attached to the RHA but in the event he was attached to Winchester Health Authority with a responsibility to offer a medical view to the County Council. The County Council had pressed very hard prior to reorganisation for a single medical view rather than one from each DHA. A paper to the JCC of 24.5.82 suggests that there should be two Community Physicians, one providing advice to the Education Department and another to Social Services and the rest of the County Council. At the time of writing LCP fulfils both functions - a very difficult task. This seems to indicate a reduction in the importance attached to collaborative working.

Proposals which will alter and widen the scope of the joint finance scheme are now in the process of being introduced. In July 1981 the government published the White Paper "Care in the Community" (DHSS 1981b) which set out a number of different ways of transferring resources and patients from the NHS to the personal social services. Following the consultative exercise the government announced in the summer of 1982 that there would be no extra funds to do this but that flexibility in the use of existing funds would be increased in two stages. No legislation would be required for the first stage which would extend the maximum period of joint financing from seven to thirteen years with 100% funding up to ten years, reserve £15 million of joint finance for pilot projects to explore and evaluate different ways of transferring people and resources to community care, and permit DHAs to guarantee annual payments to bodies taking over the care of patients. Legislation was needed to amend the rules to permit payments for education and housing. The Health and Social Services and Social Security Adjudications Act 1983 now provides the statutory permission for such payments. A new circular was issued by the DHSS in March 1983 which set out the decisions on the suggestions made in "Care in the Community", provided guidance on follow-up action, and consolidated and modified as necessary previous guidance on joint finance arrangements. (DHSS HC (83) 6: LAC (83) 5). The circular made it clear that DHAs could make lump sum

payments or continuing grants to local authorities or voluntary bodies for as long as necessary for identified patients moving from hospital to community care. This lump sum can come from DHA's main allocations, supplemented as necessary by joint finance, which may be particularly useful in meeting the extra costs often incurred when an institution is running down. Eventually the government intends to arrange a central transfer of resources from health to social services. In order to meet any difficulties arising from manpower limitations, which in Hampshire were as important as difficulties over take-up, the circular suggests that staff financed from these NHS funds will not place any additional burden on the rates, and therefore should not be counted in any manpower watch. Finally the circular announces the government's intention to introduce an amendment to the Health and Social Services and Social Security Adjudications Bill which will provide for additional members of JCCs to be appointed by voluntary organisations.

This circular and the new legislation go some way to meeting the criticisms of the organisation of joint finance during the period of this study. The major financial difficulty - that of take-up - will be helped by the extension of joint finance and the lump sum payments. It will extend joint finance into areas like housing and education which are necessary components of a definition of collaboration which includes prevention and positive health. The earlier scheme was directed at preventing people being admitted to institutional care; the new proposals are directed at returning those in institutions to the community where appropriate. The proposals may produce more integration between health and social service agencies, but the full integration proposed by the Dawson report in 1920, Sir John Maude in his note of dissent in the Guillebaud Report in 1956, and Kenneth Robinson in the First White Paper in 1968, does not seem any nearer. There seems little support for it inside the services themselves, although academics from time to time raise the issue again. Regan and Stewart in the spring issue of "Social Policy and Administration" in 1982 again argue the case for local, independent, authoritative, elected health authorities, and dismiss problems of finance and the fears of the doctors which have defeated previous attempts to introduce an integrated system of health and welfare (Regan and Stewart 1982).

However, as David Owen, father of the joint finance scheme, points out, administrative change is not the only answer.

> "Over the past few decades we have grown used to thinking that administrative change holds a secret key to improving society and have too often ignored the necessity for attitudinal change. Administrative change has too often been an excuse for not facing up to the harsh reality of the need to put more financial resources into an area which is causing concern".
>
> (Owen 1976)

The introduction of joint finance was an attempt to face some of the harsh realities in the area of collaboration and it has provided a means for starting to bring about the attitudinal change vital if collaboration is to be fruitful.

Summary

This chapter has discussed the initial expectations of the joint finance scheme, the influence of personality and structure in collaboration, and the need to have time for social learning. It has assessed the effectiveness of the scheme in Hampshire in promoting collaboration and innovation and outlined the proposals which have the potential to increase collaboration still further.

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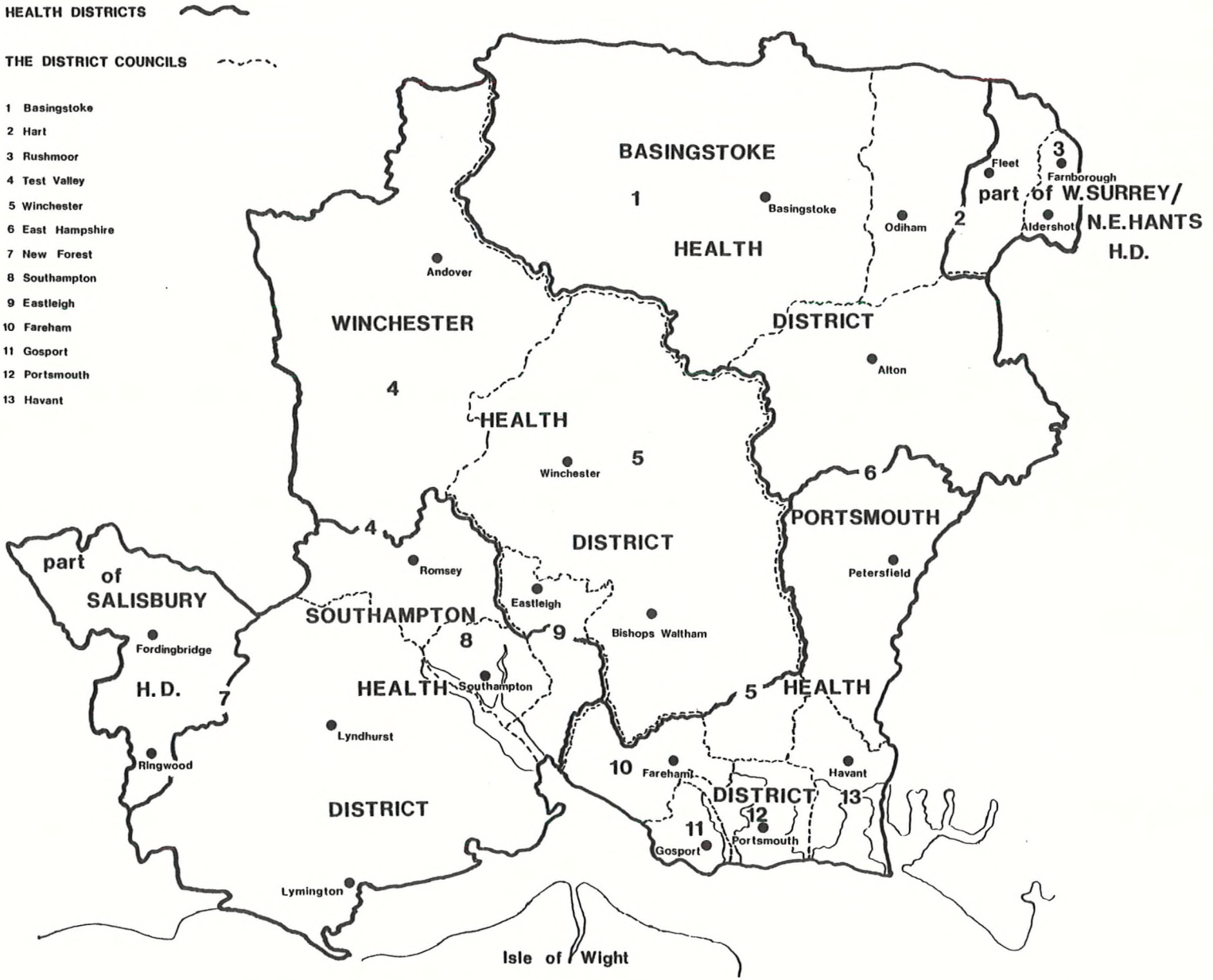
APPENDIX 1. HAMPSHIRE



APPENDIX II LIST OF COMMITTEE MEETINGS ATTENDED

1.	Joint Finance Executive	3.6.80
		12.6.80
		22.7.80
		19.8.80
		16.9.80
		21.10.80
		24.10.80
		2.12.80
		21.1.81
		17.3.81
		28.4.81
		6.7.81
		11.8.81
		22.9.81
		27.10.81
		12.1.82
		2.3.82
2.	Joint Care Planning Team	19.5.81
3.	Joint Consultative Committee	21.5.80
		17.11.80
		23.3.81
		8.12.81
		24.5.82
4.	Social Service Committee	18.7.80
		19.9.80
		30.1.81

APPENDIX III

INTERVIEWS

A. General

Specialist in Community Medicine, Social Services Liaison.

Associate District Administrator, Portsmouth Health District.

District Community Physician, Southampton Health District.

Service Planner, Southampton Health District.

Associate District Administrator, Basingstoke Health District.

Management Accountant, Area Health Authority.

Administrator, Area Health Authority.

Assistant Director of Social Services, Hampshire County Council.

Project Development Assistant, Social Services Department.

Health Services Liaison Officer, Social Services Department.

Research Officer, Social Services Department.

Principal Assistant, Corporate Planning Department.

County Councillor.

County Councillor.

Chairman of Social Services Committee/AHA Member.

Area Health Authority member.

Secretary, Hampshire Council of Community Service.

B. Case Studies

i) Housing Assistant Scheme

Assistant Director, Social Services Department.

Section Head, City of Southampton Housing Department.

Deputy Principal Area Officer, Shirley Social Services Department.

Organising Secretary, Southampton Council for Community Service.

Housing Assistant, Shirley Area Social Services Office.

ii) Living, Working and Dying Course

Administrator, Wessex Region Cancer Care Organisation.

Training Officer, Social Services Department, South West Division.

Principal Officer (Health) Social Services Department, South West Division.

Assistant Principal Officer (Health), South West Division.

Consultant in Continuing Care, Countess Mountbatten House.

Former Social Worker, Radio-therapy Department, Royal South Hants Hospital.

APPENDIX IV

JOINT FINANCING: PROPOSAL FORM

Approvals	
JCPT/SG	
JCPT	
SSC	
JCC	
AHA letter	

Social Services Division/ Health District	Year:	Ref:
Title:	Client/Service Group(s)	

Objective to be achieved, anticipated benefits etc:

Within Guidelines/Policy plan?

Action Programme:

Timescale (showing phasing where appropriate):

Implementation problems and steps to overcome these:

Land and/or
Premises: Existing/to be acquired. Where?

Nature of Joint Consultations to date:

e.g. H.C.P.T./Division/District Management Teams/Other:

Suggested funding arrangements: (for resource implications see over)

Resource Implications:

1. Estimated Capital Costs
   (Land, Equipment, Fees etc.)

2. Estimated Revenue Costs

STAFF (indicate new/existing)

Full Year				Part Year			
Grade	F.T. P.T.	No.	Cost £	Grade	F.T. P.T.	No.	Cost £

3. Other full year Revenue Costs
   (please specify)

Cost £

Health District/Divisional
Officer concerned: _____ Phone: _____

Please return one completed copy to:

(a) Health Districts: Mr. D. Johnson A.H.A. (T))
(b) Social Services: Mr. M. Gardner, Headquarters))Winchester

Date: _____

DISCUSSION GROUP LEADERS:

Carol Kennedy	Social Worker
Mary Millar	Psychiatrist
Wanda Nash	Nurse
John Sharpe	Chaplain
Frances Sheldon	Social Worker

ORGANISING COMMITTEE:

Ian Allured	Assistant Principal Officer, Social Work Office, Southampton General Hospital.
Andrew Hayes (Course Organiser)	Administrator, Wessex Regional Cancer Organisation, Royal South Hants Hospital.
Richard Hillier	Consultant Physician, Countess Mountbatten House, West End.
Rosemary Lancaster	Clinical Trials & Information Officer, Wessex Regional Cancer Organisation.
Hazel Osborne (Course Chairman)	Principal Officer, Hampshire Social Services.
Ernie Pepys	Training Officer, Hampshire Social Services.
Brian Sartain	Divisional Nursing Officer, Southampton.
Emy Wilcox	Ward Sister, Hamilton Fairley Ward, Royal South Hants Hospital.

With grateful thanks to Dr. Pamela Ashurst for her advice and support.

WESSEX REGIONAL CANCER ORGANISATION

Royal South Hants Hospital
Graham Road, Southampton. SO9 4PE

Tel: Secretariat: (0703) 34288 Ext.447/8
Clinical Trials and Information Service: (0703)29653

WESSEX REGIONAL CANCER ORGANISATION

and

HAMPSHIRE SOCIAL SERVICES DEPARTMENT

LIVING WORKING AND DYING

ASPECTS OF CARE FOR THE CRITICALLY ILL

A series of lectures and discussion groups for a multidisciplinary audience. To be held in the Postgraduate Centre, Southampton General Hospital on Thursday afternoons, commencing 10th January 1980.

FINAL PROGRAMME

LECTURES 2.30pm - 5.30pm

10 JAN LIVING WITH CANCER

Dr. Peter Maguire, Senior Lecturer in Psychiatry, Manchester.

24 JAN BREAKING BAD NEWS

Dr. Sandy Burnfield, Clinical Assistant in Child Psychiatry, Winchester.

7 FEB EFFECTS AND CONFLICTS OF CANCER TREATMENT

Mr. Bob Tiffany, Director of Nursing Royal Marsden Hospital.

21 FEB THE EXPERIENCE OF LOSS

Dr. Pamela Ashurst, Consultant Psychotherapist, Southampton.

28 FEB LIVING WITH A DYING CHILD

Mrs. Jane Davies - a mother

20 MAR WORKING WITH DYING: THE COST TO THE CARER

Professor Bob Wrenn, Director and Professor of Psychology, The University of Arizona

3 APR TOWARDS A COMMON GOAL: THE TEAM APPROACH

Miss Pam Debney	Home Care Team Leader
Dr. Richard Hillier	Consultant Physician
Miss Bridget Peters	Occupational Therapist
Mrs. Frances Sheldon	Social Worker
	Countess Mountbatten House

10 APR AFRAID TO LIVE AND AFRAID TO DIE

The Most Reverend Metropolitan Anthony of Sourozh, The Russian Orthodox Church.

TEA BREAK

Discussion Groups 3.45 - 5.15pm

Course members will be allocated to discussion groups at the beginning of the course in the hope that groups will retain a constant membership throughout the series of meetings. Allocation will be based on the principle of ensuring that each group contains a wide mix of professional disciplines. There will be five groups with a maximum of ten members each.

PROVISIONAL ARRANGEMENT: 2.30p.m. 24th APRIL PLENARY SESSION FOR DISCUSSION GROUPS.