

DELIVERING COMMUNITY CARE IN SCOTLAND: CAN LOCAL PARTNERSHIPS BRIDGE THE GAP?

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INTRODUCTION

Partnership working has increasingly been viewed as an important strategy to encourage the co-ordination and delivery of public services. However, the requirement of public sector agencies to work together in the planning and delivery of services is not new. The previous Conservative government's chosen medium was the market with its emphasis upon competition and choice which had the intended effect of controlling costs using a mixed economy of care (Le Grand and Bartlett 1993). Under 'New Labour' the language used is one of partnership and joined-up working – interagency working between public sector organisations. Although this new agenda appears to be a different ethos from the past, to some extent it builds upon the previous Conservative government's policies (Paton 1999). Where there was once an element of discretion about taking part in partnership working, there is now a 'duty of partnership', which has led to an increase in the quantity and quality of inter-agency working. This analysis will focus on partnerships between the National Health Service (NHS) and local government in the delivery of community care services. Community care services are services

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aimed at several key groups of people often referred to as client groups. These groups include:

- Older people
- People with physical and sensory disabilities
- People who are mentally ill or who have dementia
- People with learning disabilities
- People with HIV/AIDS
- People with drug and alcohol problems
- People with brain injuries
- Carers

The main objectives of community care services are to enable people to remain in their own homes supported by seamless services based upon need. Community care services include: domiciliary services such as home helps, adaptation to homes (such as the installation of chair lifts), meals on wheels, travel to day centres, housing, supported employment opportunities and residential and respite care (Scottish Parliament 2001).

Partnership working is far from easy and the advantages and disadvantages of using partnerships for service delivery are well documented (Wistow 1982, Benson 1983, Challis et al 1988, Palfrey et al 1991, Webb 1991, Bryson and Crosby 1992, Huxham 1996, Huxham 2000 and Ansari et al 2001). Evidence concerning their benefits, however, are few (Asthana et al 2002). It is interesting to note that given these problems, both the Holyrood and Westminster governments still view partnership and joined-up working as a key vehicle for delivering public policy.

JOINED UP GOVERNMENT

The Labour Party's election victory in 1997 followed a sustained period of modernisation that according to Newman (2001) had reflected developments on the wider political stage. Across much of Europe and the United States, efforts had been made to promote a new political settlement that could meet the challenges of the global economy and provide a new philosophical edge for social democracy, while, at the same time, remaining distinct from the ideologies of the 'New Right'. The process of modernisation in Britain also

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had much to do with a lack of electoral success and a desire on the part of 'New Labour' to disassociate itself from the electoral liabilities of 'Old Labour'. Politically, the 'Third Way' was an attempt to locate 'New Labour' in a position of electoral advantage with clear water between it and both the 'New Right' and the 'Old Left'.

Against this political backdrop, Labour's attempt to promote their 'Third Way' rested heavily upon joined-up government. Wishing to avoid being associated with either markets or hierarchies, the 'Third Way' attempted to ensure that policy making was more joined-up and strategic. Lying at the heart of the issue, Labour believed that public service reforms in the previous 20 years had been concerned principally with improving value for money. Too little emphasis had been paid to the policy process, how it meets the needs of people, particularly when these needs must be met across organisational boundaries (Cabinet Office 1999). In practical terms Pollitt (2003) has summarised the aspirations of joined-up government as follows:

- Situations in which different policies undermine each other can be eliminated.
- Better use can be made of scarce resources.
- Synergies can be created through the bringing together of different key stakeholders in a particular policy field or network.
- It becomes possible to offer citizens seamless rather than fragmented access to a set of related services.

HEALTH POLICY IN SCOTLAND

Health was a key target for Labour's dissatisfaction with the way in which public services had been reformed in the 1980s and 1990s. Previous Conservative administrations had been instrumental in creating an NHS in their own image. The 1980s had been dominated by new management structures influenced as they were to a significant degree by private sector management imperatives associated with efficiency, effectiveness and value for money (Griffiths 1983, Harrison et al 1988). In the 1990s the NHS was radically transformed across the UK into an organisation that became increasingly fragmented with health planning and operational management at a local level separated by the purchaser-provider split. The logic of the purchaser-provider split was to create public competition and in so doing

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sensitise the NHS to market forces (Forbes 2000). Health Boards were reinvented as purchasers of health care and NHS hospitals became providers of health care recast as NHS Trusts with relationships between purchaser and providers formalised through contractual agreements.

During their opposition years, Labour had fervently opposed the competitive market ethos, frequently arguing that it lacked patient focus and was wasteful of resources. Consequently, in its first significant policy pronouncement on the NHS in December 1997, Labour pledged itself to implement what they described as ‘integrated care’, based on partnership and driven by performance (Department of Health 1997). This was buttressed by pledges that the new approach would allow professionals to focus upon patient needs, avoid needless duplication and patients being passed from pillar to post amongst competing agencies. The promise of greater integration was to take place against the backcloth of national standards of excellence, together with incentives and sanctions for improving quality.

The sentiments of retreating from the market that were expressed in England were echoed in Scotland where **Designed to Care** extolled the virtues of ‘integrated clinical services which deliver seamless care’. To deliver this vision, partnership working was envisaged between the Government and the people of Scotland, between professionals and patients, between different parts of the NHS and finally, between the NHS and other organisations, for example local government and the voluntary sector, who might improve health and services to patients. (Scottish Office Department of Health 1997a). The organisational ‘fix’ that was prescribed in Scotland differed from arrangements south of the border. Indeed, since devolution in 1999, the differences between the NHS in Scotland and organisational arrangements subsequently developed in England have become more pronounced. **Designed to Care** retained 15 Health Boards, though, rather than operating as purchasers of services, they had again assumed general responsibility for service planning and health improvement. Existing NHS Trusts were reduced in number from 47 to 27 and a new form of Trust – Primary Care Trusts – were created. Primary Care Trusts were responsible for delivering GP-based services alongside care in the community. The geographical boundaries of Primary Care Trusts were identical to that of Health Boards. Greater Glasgow and Lothian were exceptions in as much as their geographical boundaries contained two Primary Care Trusts. At an operational level, GPs were invited to form Local Health Care Co-operatives to cover natural communities that varied in population size from 25,000 to 150,000. These Co-operatives

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delivered primary and community care services across a defined area and were separate management entities, though it was intended that they should operate as an integral part of the Primary Care Trust. For a more thorough analysis of the organisational status of the NHS in Scotland at this time see Bruce and Forbes (2001).

The changes outlined above were designed to reduce the fragmentation associated with the competitive market and in its place promote co-operation and partnership across the Scottish NHS. These changes within the context of the NHS in Scotland were consistent with the bigger picture that was emerging from the then Scottish Office and, following devolution in 1999, the Scottish Executive. Soon after devolution, **Making it Work Together** (Scottish Executive 1999) outlined the newly established Scottish Parliament's position on partnership working across the full range of its responsibilities and to realise what it considered to be the real promise of devolution. **Making it Work Together** even received special mention as an exemplar in the Cabinet Office's prescriptions for strengthening cross cutting policies and services in Whitehall (Cabinet Office 2000). However, in spite of the considerable rhetoric that had been emanating from the Scottish Office and subsequently the Scottish Executive, it can be argued that partnership aspirations lacked substance in some key areas. This was evident especially with regard to community care as there had been little progress in this area until the publication of the NHS Plan for Scotland (Scottish Executive 2000a).

The prescriptions contained in **Designed to Care** were dominated by the acute and primary care sectors and, while both have an input into community care, governance arrangements and tangible aspirations for the delivery of community care *per se* were conspicuous by their absence. Community care in Scotland has had a chequered history, marred by a lack of real political support at both central and local levels, coupled with an apparent reluctance to find ways and means of bringing local government and the NHS together to deliver joined-up services. The plight of community care as an integral part of the NHS has also been exacerbated by the emphasis that continues to be placed upon the acute hospital sector, often to the detriment of the less politically salient needs of the most vulnerable individuals.

THE JOINT FUTURE INITIATIVE

The conspicuous absence of early detailed consideration of community care needs to be set against the backcloth of a historical division of responsibilities between local government and the NHS (Hunter and Wistow 1987; Hudson and Henwood 2002). From the creation of the welfare state in the post war period to the present day, community care has fallen awkwardly between the two stools of local government and the NHS. Reorganisation of the NHS in 1974 and local government in 1975 saw attempts to tackle the issue of divided responsibilities through the creation of local government and NHS boundaries in Scotland that were geographically coterminous and could employ joint planning and finance. The 1980s saw community care being revisited again to find other ways of bridging the gap (Audit Commission 1986; Griffiths 1988), resulting in the creation of a market approach to the delivery of health and social care with local government charged with the leading role for commissioning care (Department of Health 1989). In Scotland the influence of the market was scaled down from 1997 onwards having had substantially less effect upon the commissioning role of local government in Scotland compared to England (Curtice 2000). In Scotland, there also appeared to be a lack of evidence to assess the extent to which the market had encouraged a move towards seamlessness or, alternatively, had had the effect of driving a wedge between the two. Yet in spite of community care being a prime example of a priority area that could benefit greatly from Labour's emphasis upon joined-up government, the then Scottish Office had appeared slow to respond to the challenge.

The first mention of community care since the election of Labour in May 1997 came in August of that year with the production of **Priorities and Planning Guidance** (Scottish Office Department of Health 1997b), though this merely promised guidance before the end of 1998. **Modernising Community Care** (Scottish Office 1998) then appeared late in 1998 though it is questionable the extent to which this could be described as any kind of plan at all. This document showed more visible signs of thinking aloud than of announcing an action plan. It had rejected bringing health and social care together in one organisation but its vision of how local government and the NHS were to work together to deliver services jointly was still under construction. There was no overall view on how joint planning was to be organised in terms of new powers, budgetary arrangements and local commissioning. Moreover, would it be too cynical to ask whether the then Scottish Office's thinking was joined-up as the community care initiative was

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running alongside the implementation of changes contained in **Designed to Care**? If a holistic solution to community care was to be sought, why then was the concept of partnership working in the delivery of community care not built into the reforms from the outset?

Following the establishment of the Scottish Parliament and the appointment of Susan Deacon as the Minister for Health and Community Care, some movement was detectable in terms of the way ahead for joint working. The Joint Future Group was established with the main aim of finding ways to improve joint working to deliver modern and effective person-centred services (Scottish Executive 2000b). The report of the Joint Future Group believed that while community care was at that time much better organised than in the past, joint planning was some way ahead of joint financing and there was a long way to go in terms of consistently delivering quality services to people across the country. The essence of the Joint Future Report sought to establish partnerships between the NHS and local government to deliver improved services to the elderly in the first instance. This would be extended to all client groups the following year. These partnership arrangements were accompanied by new financial arrangements that were to be based initially upon a system of aligned budgets with aspirations to move to a more integrated system of pooled budgets. This would be underpinned by a stronger lead from the centre through national financial, planning, and service management frameworks to forge relationships between agencies, to set objectives and to monitor performance. Locally a system of Single Shared Assessment was to be introduced to streamline, coordinate and provide a more structured exchange between the user and assessor (Scottish Executive Health Department 2001b). The Assessments are where clients needs are assessed jointly by both the local authority and NHS at the same time (McTavish and Mackie 2003). Like **Modernising Community Care**, Joint Future rejected bringing health and social care together in one organisation. It is interesting to note, however, that the 16th Report of the Health and Community Care Committee, which had reported in the same month as Joint Future, had embraced the concept of a single body with budgetary, planning and commissioning responsibilities with a view to creating a greater sense of cohesion in the delivery of community care (Scottish Parliament 2000).

The main thrust of the Joint Future Report was accepted and acknowledged in the NHS Plan for Scotland when it was published at the end of 2000. There were, however, some aspects of the Joint Future Group's recommendations that had only been accepted in principle. The Scottish Executive wished to

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have more time to consider the implications of the National Planning and Financial Framework (The Scottish Executive 2001). It was not until September 2001 that guidance was issued with respect to joint working and finance (Scottish Executive Health Department 2001a) and this was closely followed by guidance on Single Shared Assessment (Scottish Executive Health Department 2001b). The Joint Future Group had initially envisaged partnerships to be operational by April 2002 but this had to be delayed until April 2003 with the requirement that partnerships broaden their remit to embrace the full constellation of community care client groups from April 2004. The vehicle for partnership working was through Local Partnership Agreements between the NHS and local government which sought to establish arrangements for the joint management and resourcing of community care services.

In terms of joined-up government in Scotland, community care was a relatively late starter, due to become operational some seven years after the 1997 election that had brought with it the Blairite philosophy of the 'Third Way'. Nevertheless, the challenges associated with securing improved delivery of community care in Scotland remain significant and, in the absence of a single organisation responsible for the delivery of community care, the successful implementation of joined-up government is not an option – it is essential. Yet what is it about this approach to delivering joined-up services that promises success where previous attempts have failed? Joint Future represents a significant change agenda for organisations that have in the past not always shared the same views over means and ends. Nor indeed, have they always demonstrated that they are at one with respect to willingly committing resources to joint initiatives (Hunter and Wistow 1988). This is likely to be the crux of the matter as it is seen through the lenses of the Joint Future agenda. In order to successfully implement Joint Future's recommendations, significant progress needs to be made on the key issues of joint management and joint finance. Allied to this, the role of the centre needs to be more effective than in the past, providing strategic leadership and a structured approach to the organisation and delivery of care in the community that is appropriate to locally defined needs.

MAKING A REALITY OF JOINT WORKING?

Community care has suffered from a historical division of responsibilities between local government and the NHS. Given the Scottish Executive's drive

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to improve the delivery of community care, the authors embarked on a longitudinal study beginning in July 2003 to examine this process. The main research question for the study is 'will Joint Future be likely to succeed where previous attempts to achieve seamlessness in the delivery of community care have failed?' The empirical material that is outlined here was derived from a series of 18 semi-structured interviews that were undertaken between July and November 2003 in four partnership areas. These interviewees were chosen from a range of people who were involved in the implementation of Joint Future and included chairs of policy and management committees, senior members of Joint Management Teams and a senior civil servant at the Scottish Executive's Joint Future Unit. To help answer the research question, the interviews were framed by a number of core areas which included: how participants conceptualised joint working; the need for joint working; relationships with the Scottish Executive; difficulties associated with joint working; and the achievements of joint working so far. The interviews were supplemented by an examination of key policy documents produced by the then Scottish Office and now the Scottish Executive.

The partnership areas for this study were selected with a view to providing a relatively varied selection of local circumstances. They were not intended in any way to be a representative sample of all partnership arrangements in Scotland but sought to identify a limited number of partnerships that could provide early indications of their experience of developing a policy response to Joint Future. Some caution therefore must be exercised in drawing definitive conclusions from this relatively small sample. In addition, explicit recognition is given to the fact that, when this research was carried out, Joint Future was at an early stage of development. However, in taking a longitudinal view of any policy development, it is important to identify key issues from the outset as the formative stages of any policy initiative is likely to have a lasting impact upon the nature and scope of subsequent developments. Additionally, during the early stages of development, there were many user groups that were not as yet part of the Joint Future initiative. Consequently, a decision was taken to examine partnership working in a broad sense rather than adopt multi-level analysis across a range of user groups.

At the outset it became clear from the individuals who had been interviewed that the centre wished to see partnership working being progressed at a brisk tempo. The speed at which partnerships had to be established caused some friction locally and generally, there was a feeling that the centre's agenda was

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driven by process – ensuring the guidance from the Scottish Executive was followed – rather than substance. In spite of this, it was possible to detect considerable optimism and enthusiasm about what partnerships may achieve in the years to come, with several key participants indicating that they believed this approach to joint working was likely to be more successful than previous attempts. Clear recognition had been given to the fact that both the NHS and local government served the same client groups and it was recognised that, in order to make best use of the resources available to community care, greater effort needed to go into joint working. Going beyond the issue of resources, it was also recognised that taking care of a common problem needed single door access so that clients and their carers were receiving more co-ordinated services.

In some senses it was easier to agree upon the broad principles that provided the rationale for a partnership approach than it was to marry many of the strategic and operational considerations that would secure effective partnership working. It was clear from the outset that as well as differences being evident between partnerships in terms of progress towards joint working, there were also differences within partnerships. A key challenge was to bring strategic, middle and operational management together but it was as yet rare to find strong evidence to indicate that this marriage had been successful. Exceptionally, one partnership had strategic planning groups across all areas of community care, not just the elderly. These groups were examining policy matters and trying to identify resource streams in support of policy thinking. Otherwise, many of the developments during the first year that partnerships had been in operation tended to be small scale and usually opportunistic in areas as diverse as services for people with learning difficulties and health improvement schemes. On the positive side, until partnerships become more trusting and sophisticated, it may be easier to develop small scale projects where agreement can be reached in respect of objectives and financial resources. However, there were aspects of partnership working that represented significant challenges to our partnerships. It is on these challenges the analysis will now focus.

CULTURAL DIFFERENCES

Differences were evident between the two organisations with respect to the medical and social models of care. On the NHS side there were indications to suggest that it was difficult to engage those in the primary and acute sectors

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into accepting the rationale for managing and delivering services across organisational boundaries. Operating outside their silos seemed contrary to the comfort zone of the medical model of care that tends to emphasise individual decision-making between practitioner and patient (Hunter 1994). Conversely local government exhibited more of a tendency to embrace the social model of care that is assumed to be more suited to delivering services across organisational boundaries (Meads and Ashcroft 2000). The reality, however, between the two models of care may be more apparent than real with differences due to tribalism associated with professional rivalry, custom and practice. Hudson and Henwood (2002) point to the example of Northern Ireland where Health and Social Services Boards have had united health and social care together in one organisation since the early 1970s. In spite of services being brought together into one organisation, a recent report (NHS Executive Social Services Inspectorate 2000) has indicated that a more coordinated approach to planning and management is still needed with better collaboration across hospital, primary and community care.

Cultural differences can also be expressed through the way in which individuals related to each other on an interpersonal basis, preferring to use particular styles of language and symbolism that do not easily cross professional boundaries. In addition to this, a local government Social Services Manager was much more forthright in the analysis of inter-professional and inter-organisational rivalries stating clearly that 'you have to be careful what you say in certain circumstances'. His justification for this was that owing to cultural differences there was a danger of misinterpreting what may have been proposed and agreed – a mini Tower of Babel. Another respondent reinforced this aspect of cultural rivalries between the NHS and local government, having been forced to deal with a long and entrenched history of professional differences.

ORGANISATIONAL DIFFERENCES

A key feature of the organisational differences that existed between the NHS and local government was the absence of organisational coterminosity. This was brought into sharp relief with respect to geographical boundaries that in some instances differed quite markedly. Only one partnership in the sample had boundaries that were geographically coterminous between local government and the Primary Care Trust. The remaining partnerships had local government boundaries that were all located within a larger health board

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area and therefore not coterminous with the Primary Care Trust. In one geographical area, the local government boundaries were coterminous with the Local Health Care Co-operative while another two local authorities shared a Co-operative. It is also recognised that outwith the sample frame, there were configurations of local authority, Primary Care Trust and Local Health Care Co-operative boundaries that were much more complex resulting in multi-agency partnerships. For example, NHS Greater Glasgow needs to forge partnerships with six local authorities and each of these local authorities must also have partnership arrangements with the four NHS Boards that border Glasgow. There was also a sense in which yet another reorganisation of the Scottish NHS envisaged for 2004 but delayed to April 2005 had created a degree of uncertainty in partnership working, with Local Health Care Co-operatives due to be replaced by new bodies in the shape of Community Health Partnerships (Scottish Executive Health Department 2003).

Within each of the partnerships there was also evidence of differing management and organisational arrangements and a number of respondents had suggested that this might be problematic in relation to joint working. In addition to concerns expressed over organisational structure, there were also concerns about the management process, especially regarding leadership. Local government tended to be very hierarchical in their management processes with a number of layers having to be passed through before a decision was precipitated with a clear line of accountability.

The NHS on the other hand differed markedly with one respondent indicating that there was more shared leadership between clinicians and management. This effectively meant that there were two different management processes addressing the same major change agenda. In addition to differing managerial structures and processes that had frustrated joint working, there was a more general lack of knowledge of how partners organise and take decisions, and, more prosaically, of who is responsible for certain tasks. In some respects, this might be explained quite simply through joint working being in its early stages. Alternatively, there may still be an organisational inertia that Joint Future has so far been unable to tackle, with the result that local government and the NHS are still better equipped to meet their own agendas rather than effectively breaking down organisational barriers in the delivery of health and social care with both partners viewing each other with a degree of suspicion. The climate of suspicion was not helped by a belief that was often articulated on the local government side that Joint Future represented a centralist agenda

and that partnership with the NHS represented an attempt to compromise their autonomy.

FINANCIAL DIFFERENCES

The achievement of a workable approach to managing the financial dynamics of partnerships is a key element in securing success. In the first instance partnerships were expected to adopt aligned budgets. This involved the grouping of separate budgets to improve the joint planning and deployment of resources. Decisions are taken collectively but individual accounts are still held within the separate organisations, allowing them to identify and account for their own contribution. Pooled budgets, on the other hand, require organisations to contribute to a 'pool' that is committed and accounted for against the joint aims of the partners. A key issue with respect to pooled budgets is that they are hosted by only one of the partner agencies (CIPFA 2002) although for a variety of reasons the idea of pooled budgets was seen as being too much too soon. This was a view that was also shared by the Scottish Executive who by end of the research period had retreated from its support of the Joint Future philosophy concerning the desirability of implementing pooled budgets to accepting the reality that it would be difficult to move partnerships from aligned to pooled budgets for anything other than small scale projects.

Aligned versus pooled budgets aside, there was the impression given by some respondents that differences existed within the financial regimes of both the NHS and local government that did not lend themselves easily to joint financial planning. Comments were received to the effect that each organisation had different financial cycles and different methods of funding. Local authorities believed that they had a far greater degree of freedom in allocating and spending resources compared to the NHS and this was attributed not just to a different funding regime but also to accountability. A counterbalance to this position, however, could be found in responses from those in the NHS whose belief was that their own organisation was more financially dynamic than their local government counterparts. It was also suggested on several occasions that there was a sense in which many of those differences were not thought to be significant and there is a strong likelihood that many of those financial differences were rooted in and can be explained in terms of more deeply seated cultural and political differences that exist between the NHS and local government.

POLITICAL DIFFERENCES

Political differences fell into two categories. First, there were differences associated with the bureaucratic makeup of each of the organisations and how they set about achieving their objectives. Secondly, there were differences associated with the political complexion of local government in a party political sense. With reference to organisational politics, a key political difference that was noted between the NHS and local government related to the nature of accountability. In the NHS, members are appointed by the Minister to whom they are directly accountable. Conversely, local government does not have the same direct relationship to the centre. Local councillors are elected by the local population and, as such, see themselves as being much more directly representative.

There are several issues associated with this, not least that local councillors will tend to be much more vocal in the use of resources, seeing this as a core activity. An implication of this more highly politicised stance that can be taken by local councillors is of seeing partnership with the NHS as an erosion of their power and legitimacy if it is the partnership that is deploying resources. It is for this reason that many local government officers indicated that many councillors have been extremely suspicious of pooled budgets. That aside, there was a general tendency for elected politicians locally to be much less welcoming of the centralist agenda, with the NHS being seen as something of a Trojan Horse. Some of this gulf between the centre and localities could be explained in terms of political differences, and yet, where political differences between the centre and localities were not particularly wide, there was still very clear reluctance to embrace a centralist agenda, preferring instead to value political autonomy – real or imagined.

In terms of party political makeup of local government, in one geographical area three local authorities were located within one health board boundary. In each of these local authorities there were different political perspectives that required different approaches to be adopted by the NHS. In one partnership, however, the NHS view was that if there is a will at the top to make a difference then many political, organisational and cultural differences matter less. As one senior NHS manager commented, 'you can cut through all this if the right relationships at the top are in place to develop productive ways of working'. In the last three years it was believed that relationships within this partnership had matured with all three local authorities and had created a more accommodating environment.

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There was evidence elsewhere to suggest that a process of accommodation was less well developed and one senior officer in the NHS made it absolutely clear that his response to key questions depended entirely on the political map of the area. This was supported by a senior local government officer who felt that rather than put service development first, partners tended to defend their own turf. Differences between senior managers were much less pronounced than between councillors and appointees. Senior managers often had more of an eye on the common good and had much closer working relationships with their opposite numbers than part-time councillors and appointed members.

BACK TO THE FUTURE?

It is of course recognised that at the time this research was conducted, partnerships were in the early stages of their development and realistically it will take some years before more definitive judgements can be made about their achievements. Nevertheless, in the initial stages there is no overwhelming evidence to suggest that the implementation of Joint Future has brought with it key cultural, organisational, financial and political changes. Pessimistic reflections upon what has so far been achieved by Joint Future may reveal a very strong sense of *déjà vu* in as much as there is little in this particular approach to partnership working that has not been tried at some point in the past. Is it that there is an absence of alternative strategies to promote effective joint working between local government and the NHS or is it that joint working between these two organisations is quite simply impervious to change? At the end of its first year of operation there were already indications that the Centre also felt that Joint Future had fallen short of expectations. In March 2004, the Scottish Executive issued a letter entitled 'Re-invigorating the Joint Future Agenda' (Scottish Executive 2004). The re-invigoration of an initiative that was not as yet one year old was strange to say the least, but the sub-text was that the Scottish Executive was seeking to change the emphasis from a process-driven to an outcome-driven approach that focused upon benefits to individuals and their carers. But what is the danger in this move to an outcome based approach? No matter how well it may be designed 'Reinvigorating Joint Future' may well be lost amongst a raft of other initiatives that were going on in and around the Joint Future agenda.

In their first year of operation, partnerships were required only to address the needs of the elderly. From April 2004 partnerships were required to extend

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joint working to all aspects of community care – through Extended Local Partnership Agreements. This needs to be set against a backcloth of yet another ambitious time-table being imposed by the Scottish Executive with discernable disquiet expressed at a local level about the appropriateness of the time table. At a local level our partnerships had specifically requested that the centre delay the implementation of Extended Local Partnership Agreements. Justification for delaying the implementation was impending establishment of Community Health Partnerships so that there was a very strong sense in which the Scottish Executive may be criticised for putting the cart before the horse. Community Health Partnerships are new organisations that will from April 2005 seek to deliver services in partnership between the NHS, local authorities, the voluntary sector and other agencies. The purpose of the Partnerships is to support the improvement of the health of local communities, provide service benefits for local people and involve them in decisions that affect the planning and delivery of health and social care. The Partnerships will seek to bridge the divide existing between primary and secondary care and between health and social care and will replace service delivery mechanisms which currently are not naturally integrated (Scottish Executive Health Department 2003). As such Community Health Partnerships will be expected to absorb much of the Joint Future agenda.

It has to be remembered though that Community Health Partnerships are not solely being set up as dedicated organisations to deliver the Joint Future agenda. The reality is that the Partnerships will have a number of extremely challenging responsibilities and Joint Future will be but one amongst many. Managing independent contractor services (primary medical services, general dental services, community pharmacy and general ophthalmic services) together with all community related health services (community and public health nursing and services provided by allied health professionals) are but two areas of responsibility for Community Health Partnerships in a list of 24 (Scottish Executive Health Department 2004). In addition to what is likely to be a complex and demanding workload, the process leading up to the creation of Community Health Partnerships was itself protracted and characterised by uncertainty and confusion. During the period in which this research was conducted, it became clear that there was considerable uncertainty at a local level about where Joint Future initiatives would fit within the context of the Community Health Partnerships. This uncertainty and confusion is likely to be exacerbated if Joint Future initiatives are compromised by many competing and contested agendas in an over crowded landscape. This over crowding is likely to be particularly acute during the establishment of

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Community Health Partnerships and it will be interesting to observe how Joint Future fares in what will be its third year of operation.

CONCLUSION

The Joint Future initiative represents yet another attempt to bring local government and the NHS together to provide a more cohesive person-centred approach to delivering services to some of the most vulnerable people in society. Local government and the NHS have never been particularly closely aligned with respect to the delivery of community care and while there was a first flush of enthusiasm and optimism about the potential for the Joint Future initiative, this enthusiasm and optimism now needs to be tempered by the realities associated with key differences between each of the organisations. It is early stages in the Joint Future initiative and it is clear that partnerships will need to be given time to settle down to the task in hand, to develop viable policies and strengthen partnership working. The first year of operation was largely dominated by structure and process and of getting partnerships operational. In terms of the delivery of services, a good deal of what was happening in this formative period was driven by pragmatism. Looking to the future, there are a number of key issues – cultural, organisational, financial and political – that will need to be addressed with some measure of critical analysis if this attempt to bring local government and the NHS together is not to flounder in the same way as previous efforts.

Working in partnership with others can be fraught with difficulties, not least because there are likely to be differences in the way that partner organisations wish to interact with one another, and both the Holyrood and Westminster Governments are very much focussed on this approach to delivering public services. With respect to delivering community care in Scotland, however, divided responsibilities do not make partnership working an alternative – it is essential if services are to be delivered seamlessly to client groups that are served by both organisations. We could end somewhat cynically by suggesting that even though there is now some form of joint working resulting from Joint Future and, in turn, the prospect of Community Health Partnerships taking a leading role, there is still the same deeply ingrained problems that undermined previous attempts to deliver joined-up care. This scenario, therefore, casts joined-up government in an unfavourable light and, in this instance, condemns the Blairite approach to join-up government to the realms of ineffective political rhetoric.

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On a more positive note, we now have a debate not least about ways and means of achieving partnership working. Structures are now in place to allow such a process to occur through joint resourcing and management arrangements with local government and the NHS and there is some evidence, albeit based on small scale projects, that partnership working is now beginning to develop. It may be that the development of Community Health Partnerships may accelerate this process and with time could make significant inroads into the joint-working agenda. In the short to medium term, much depends upon the trajectory and future role of Community Health Partnerships as these new organisational forms will be charged with bridging the divide that has existed for far too long between primary and secondary care and between health and social care.

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