BRIEFING PAPER

GRIFFITHS AND COMMUNITY CARE

MEETING THE CHALLENGE

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SUMMARY

The Griffiths report, *Community Care: Agenda for Action*, is the most significant statement about community care since the Seebohm Report on the future of personal social services in 1968. This Briefing Paper provides a detailed description of the proposals and a critical assessment of the challenge they pose to all those involved in the planning, management, delivery and receipt of community care.

The community care policies of successive governments have made little impact. Reports by the Audit Commission and National Audit Office have been unequivocal in their criticism of the way community care policies have been implemented. The four so-called 'priority groups' — elderly, mentally handicapped, mentally ill and physically disabled people — are unnecessarily disadvantaged by present arrangements. Services are patchy and poorly coordinated. Too many resources are still locked-up in old long stay hospitals.

Against this background, Griffiths aims to provide a more coherent framework for policy development by improving the machinery of government and removing some of the obstacles to better value for money. The thrust of his proposals is twofold.

First, central government should take community care more seriously. A Minister should be designated to provide policy leadership and direction. This would involve promulgating values and objectives, monitoring local plans and reviewing priorities in the light of changing circumstances.

Second, local authorities should take the lead role locally, within policy guidelines specified by the appropriate Minister and in collaboration with other relevant agencies.

The Griffiths proposals pose a number of major challenges and opportunities. This Briefing Paper argues that it is not clear whether central or local government is equipped to meet them. In particular there are doubts over:

- central government's willingness to provide policy leadership and ability to undertake the major executive task of monitoring and approving detailed local plans
- central government's willingness to delegate new responsibilities to local authorities
- social services departments' ability to assume the new roles proposed by Griffiths
- social services departments' commitment to community care for the priority groups.

Resource levels for community care are an over-riding concern. Griffiths does not address this question directly but comments that having ambitious policy goals without the means to implement them is the worst of all possible worlds.

The Briefing Paper concludes that if progress is to be made on implementing the framework offered by Griffiths then the mutual suspicion between central and local government needs to be replaced by a positive commitment to move forward in a joint partnership. In this way isolated experiments which provide flexible individually tailored care for independent people might become the rule instead of the exception.

INTRODUCTION

For at least a quarter of a century successive governments of all political persuasions have been committed to developing community based services as an alternative to long stay institutional (primarily hospital) care. The emphasis has been on enabling elderly, mentally ill, mentally handicapped and physically handicapped people — the so-called priority groups — as far as possible to lead normal lives and to remain in their own homes.

Despite this general commitment, there is no consensus either about what community care entails or about the policy means to implement it. Instead of common values and shared understandings, competing models of care exist. Community care is variously defined as care outside hospitals, care outside institutions, and care outside the state. There remains confusion about what models of care should form the basis of a comprehensive community care strategy. There is also a lack of clarity over the multiple objectives of community care: these are specified variously as (a) discharging people from long stay hospitals, (b) preventing admission to hospitals, (c) unblocking acute beds, (d) cost containment, (e) developing new services, and (f) providing domiciliary rather than residential care. Policy has lacked coherence and has proceeded piecemeal.

Notwithstanding its imprecision, the concept of community care implies a shift in the balance of care from institutions to community facilities, and from health to social services. It also involves a shift of resources both within health services, and between these and social services. Finally, it requires a collaborative response from a variety of agencies and service providers operating at national, local, and field levels. Each of these aims has proved difficult to achieve.

At the close of 1986 the Audit Commission's report, *Making a Reality of Community Care*, documented the chief impediments to the development of a coherent and effective national community care policy (Audit Commission, 1986). This triggered Sir Roy Griffiths' review of community care commissioned by the former Secretary of State, Norman Fowler.

However, there had been mounting concern over the slow and uneven pace of change and the confusion that seemed to pass for policy. Two influential reports preceded the Audit Commission's by a year or so: the House of Commons Social Services Committee's (1985) report on community care — which focussed on mentally ill and mentally handicapped adults — and that of a Working Group on Joint Planning comprising DHSS, local authority association and NAHA representatives. The Working Group on Joint Planning (1985) report, *Progress in Partnership*, appeared in mid-1985 and recommended significant improvements to joint planning mechanisms.

Towards the end of 1987, the National Audit Office published the fruits of its own investigation, *Community Care Developments* (NAO, 1987). The findings broadly endorsed those of the Audit Commission. The NAO report was particularly critical of the level of progress under joint planning which was put down to 'structural differences' between health and local authorities. Consequently, 'it may be necessary for fairly radical solutions to be considered' by the Griffiths review. At this time, the Audit Commission (1987) published an occasional paper on developing services for people with a mental handicap. It reaffirmed the Commission's view that organisational problems were preventing the most effective use of resources.

Two other related official inquiries were in hand when the Griffiths review was announced: a Joint Working Party (1987) headed by Joan Firth, a senior DHSS official, was studying options on the public funding of residential care, and a review of residential care was being carried out by a team chaired by Lady Wagner under the auspices of the National Institute of Social Work (NISW). The Firth report was published in mid-1987 and was referred by Ministers to Sir Roy for a response. The Wagner report was published in early March 1988 (NISW, 1988). Its view of residential care as one of many service options that should be available to people only when appropriate is shared by Griffiths.

The Griffiths report applies only to England although its references to social security and residential care apply across the UK. Yet community care is a UK policy priority to which all four health departments subscribe. Indeed, the Secretary of State for Scotland announced at the UK social services conference in September 1987 that the four health departments would jointly consider the Griffiths report. However, community care has taken different forms in England, Wales, Scotland and Northern Ireland which will need to be borne in mind when considering Griffiths in a context other than an English one.

Against this background, this paper has three aims. First, it identifies the main obstacles to the development of community care. Second, it provides a detailed description of the key features of the Griffiths proposals placing them in a broader policy context and noting their antecedents. Finally, it assesses the challenge presented by Griffiths to all of those involved in the planning, management, delivery and receipt of community care.

ISSUES AND PROBLEMS

The Audit Commission's report, *Making a Reality of Community Care*, provides a trenchant critique of attempts to implement community care policies in England and Wales. The Commission concluded that despite some £6 billion being spent on services for the priority groups (see Table 1) progress was slow and uneven across the country. Five obstacles were identified to account for this state of affairs:

- compartmentalised health and local government budgets which hampered the desired shift in resources from health to social services and did not match the requirements of community care policies
- the absence of bridging finance to meet the transitional, or 'hump', costs involved in shifting from institutional to community care
- the distorting effects of the public funding of private residential care, which in 1986 was running at around £600 million per year and still growing rapidly — perversely, this offers incentives for residential rather than domiciliary based care
- delays, difficulties and boundary problems caused by a fragmented organisational structure (see Figure 1)
- the absence of staffing and training arrangements to ensure an appropriate supply of trained community based staff, and to ease the transfer of staff into the community.

TABLE 1 · EXPENDITURE BY CLIENT GROUP 1984-5 ENGLAND: £ MILLION, AT OUT-TURN PRICES

	Elderly	Mentally Handi-capped	Mentally Ill	Younger Disabled	Total
NHS	1,060	500	1,090	50	2,700
PSS	1,380	320	60	140	1,900
Social Security	460	30	10	190	690
Total	2,900	850	1,160	380	5,290

Source: The Audit Commission for Local Authorities in England and Wales, Making a Reality of Community Care, *HMSO, London, 1986.*

Few of these problems are new. Twenty years ago, the Seebohm Committee (1968) on personal social services was critical of 'the fragmented nature of the existing services' which tended 'to produce separate spheres of responsibility with neglected areas between' (para. 76). It went on to assert that problems of interagency coordination and collaboration 'have loomed increasingly large' (para. 79). Seebohm stressed the problems users and other providers encountered in approaching personal social services (PSS). 'People are often unclear about the pattern of services and uncertain about the division of responsibilities between them' (para. 83). Three explanations were offered to account for these major deficiencies: 'lack of sufficient resources; inadequate knowledge; and divided responsibilities' (para. 87).

In its response to the obstacles and policy conflicts which it identified, the Audit Commission put forward three 'strategic options' for further scrutiny:

- local authorities could be made responsible for the long term care of mentally and physically handicapped people
- for elderly people and their care, a single budget in an area could be established by contributions from the NHS and local authorities; the budget could be held by a manager accountable to a joint board
- for mentally ill people, the NHS could remain the lead authority but social services would also be necessary so a variant of either of the first two options might be selected.

The Audit Commission recommended that these strategic options for organising and funding community care be investigated in more detail by 'a high level review'. This led directly to the Griffiths enquiry.

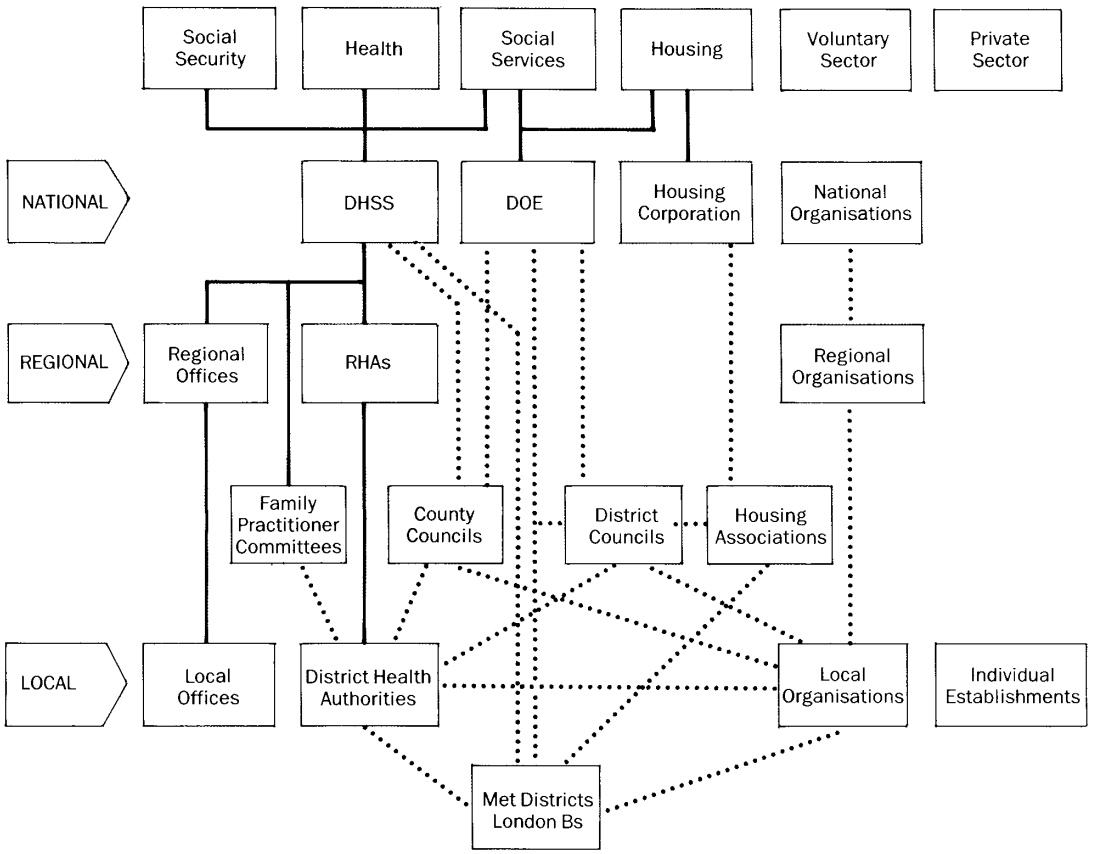
While the Audit Commission's report painted a black picture it conceded that the canvas was not uniformly dark. Examples of many good community care schemes were cited in operation although it was stressed that these had developed despite rather than because of the system. The Commission identified six features of successful schemes:

- strong and committed local 'champions' of change
- a focus on action not on bureaucratic machinery
- locally integrated services cutting across agency boundaries
- a focus on the local neighbourhood
- a multidisciplinary team approach
- a partnership between statutory and voluntary organisations.

In submitting evidence to the Griffiths Review, some bodies — including the King's Fund — argued that the Audit Commission had underestimated the amount of innovation in community care services. It was suggested that the task should be restated so that it became not one of just promoting local experiment and innovation but one of ensuring that local initiatives are evaluated and, if demonstrably successful, diffused throughout the system to ensure their widespread take-up as part of mainstream service provision and funding. Furthermore, given that there is no one best way or single model of service provision there is merit in encouraging and supporting diversity and experiment.

What is often lacking, however, is any attempt to evaluate these experiments in different ways of providing care in order to establish those that are most effective in terms of desired outcomes. There is an overwhelming need to establish arrangements whereby policy and organisational learning can take place. However, before this can sensibly occur there has to be clarity about the nature of the policy and the level of resources necessary to secure its implementation. Whereas the Audit Commission and others saw the failure of community care policy as essentially an implementation problem, many of the problems are in fact symptomatic of a persistent failure to establish and operate a clear policy framework.

FIGURE 1 · PRINCIPAL AGENCIES INVOLVED IN COMMUNITY CARE



— indicates direct line responsibility ••••indicates interrelationship

SOURCE. The Audit Commission for Local Authorities in England and Wales, Making a Reality of Community Care, *HMSO, London, 1986.*

THE GRIFFITHS PROPOSALS

Community Care: Agenda for Action (1988), the Griffiths Review, was published in March 1988, against the sombre background of perverse incentives and policy confusion outlined in the previous section. It suggests a series of major new directions. This section summarises the review's approach and recommendations. Where appropriate it also locates them in a wider context, because many of the proposals have their antecedents in other government initiatives.

Much of the critique of community care in recent years has focused attention on the inadequate organisation and delivery of *services*. The Griffiths Review starts from a rather different standpoint. The needs of the individual are paramount. The assumption is that members of the priority groups are disadvantaged therefore they need someone to look after their interests; an agent to ensure that services are provided but not necessarily to supply them directly. The more general policy objectives for community care which Griffiths recognises are to ensure:

- **the effective targeting of resources** — so that the right services are provided to the people who need them most
- **more voice and choice for the consumer** — so that the views of people in receipt of help are taken more seriously and they can choose from a wider range of services
- **a suitable domestic environment** — so that wherever possible people should be enabled to remain in their own homes.

How are these objectives to be achieved? First and foremost, the approach demands that the responsibilities of different agencies be clarified. In particular, Griffiths places considerable importance on the responsibility of local authorities. A key assumption is that:

> *If community care means anything it is that responsibility is placed as near to the individual and his carers as possible* (para. 30).

Demands for community care are so great and so varied that priorities ought to be determined by local elected representatives. In practice, this means substantially enhancing the role of existing social services authorities. It should be noted that Griffiths uses this term to refer to the social services responsibilities placed upon relevant local authorities. We will use the more familiar term — social services department (SSD) — throughout this report to mean the same thing.

Approach and Style

Before describing some of the most important proposals which Griffiths makes, it is worth emphasising one or two points about the way in which Sir Roy approached his task. This is because he appears to be sensitive about the manner in which the review was conducted and he provides a robust defence of his approach against possible critics. First, he argues that a conventional inquiry was not necessary because the Audit Commission and the House of Commons Social Services Committee had collected most of the essential facts. His job was to produce proposals for action and explain their rationale. Second, he emphasises that his principal concern is to establish the most appropriate machinery. The challenge is to ensure that resources are used as cost-effectively as possible. This implies a flexible approach to community care.

> *The aim must be to provide structure and resources to support the initiatives, the innovation and the commitment at local level and to allow them to flourish . . . To prescribe from the centre will be to shrivel the varied pattern of local activity* (para. 11).

Neither is major organisational restructuring the answer, as this would simply serve to shift the interface between authorities rather than solve problems of collaboration. Adopting a modern managerial ethos is likely to be of more benefit than organisational change.

> *Nothing could be more radical in the public sector than to spell out responsibilities, insist on performance and accountability and to evidence that action is being taken; and even more radical, to match policy with appropriate resources and agreed timescales* (para. 20).

Finally, Griffiths emphasises that his recommendations are essentially a flowchart. Considerable further work is necessary if they are accepted. Implementation will bring problems since there is no perfect solution. The reality is that any change involves choosing between second-best alternatives. One particular concern is the limited availability of data about the cost-effective use of resources.

> *The present lack of refined information systems and management accounting within any of the authorities to whom one might look centrally or locally to be responsible for community care would plunge most organisations in the private sector into a quick and merciful liquidation* (para. 28).

Matching resources to needs in the most effective way is the critical challenge for community care provision. This will not be possible without the development of much more sophisticated information systems.

Main Proposals

Griffiths makes a number of key recommendations. These include:

- a clearer strategic role for central government
- a more facilitative and enabling role for social services departments
- the continuing need for collaboration at the local level between different agencies
- new methods of financing community care
- a single gateway to publicly-financed residential care
- greater encouragement for experiments to promote new forms of more pluralist provision
- the need to establish a resourceful team within central government to implement the proposals

- establishing a better balance between policy aspirations and the availability of resources.

Strategic Central Responsibilities

A central premise of the Griffiths Review is that central government is not taking community care very seriously: national policy must be linked more clearly both to resources and timetables. A key proposal, therefore, is that a Minister should assume specific responsibility for community care.

The designated Minister of State should be properly supported within DHSS and should, *inter alia*, (a) promulgate values, objectives and standards; (b) ensure local plans are comprehensive, complementary and consistent with national policy; (c) monitor and review the development of local policies; and (d) revise national policy in the light of changing circumstances.

In discharging these responsibilities, however, central government should leave the responsibility for the detailed content of plans and activities to be determined by the local agencies.

The Enabling SSD: Promoting a Mixed Economy of Welfare

What Griffiths has in mind for the personal social services is both evolutionary and radical. Evolutionary in that he builds upon the 'one door' philosophy of Seebohm and the importance of social care planning articulated by Barclay. Radical in that he forcefully advocates a more mixed economy of social care.

> *The primary function of the public services is to design and arrange the provision of care and support in line with people's needs. That care and support can be provided from a variety of sources. There is value in a multiplicity of provision, not least from the consumer's point of view, because of the widening of choice, flexibility, innovation and competition it should stimulate. The proposals are therefore aimed at stimulating the futher development of the 'mixed economy' of care. It is vital that social services authorities should see themselves as the arrangers and purchasers of care services — not as monopolistic providers* (para. 3.4).

This latter conception is very close to the 'enabling' role for social services departments articulated by the former Secretary of State, Norman Fowler, at the annual joint social services conference at Buxton in 1984. Fowler suggested that SSDs have 'three paramount responsibilities'.

> ***First**, to take a comprehensive view of **all** the sources of care available in its area, and to take full account of these in plans to meet local needs. **Second**, to recognise that the direct provision of services is only **part** of the local pattern and that in many cases other forms of provision will be preferable. **Third**, to see a major part of its function as promoting and supporting the fullest possible participation of the other different sources of care that exist or which can be called into being.*

The overarching responsibility for social services departments is to see individuals in their total or overall situation. First, they must assess the needs of individuals. Second, they must determine what package of social services provision is appropriate in relation to that assessment and the availability of resources. This raises important issues about the management and delivery of social services. It is not necessary, Griffiths suggests, for social services departments to provide all funded services themselves.

Local authority social services should be reorientated away from an emphasis on the provision of services to one which emphasises case management and involves a more facilitative and enabling role. The critical task is to improve the targeting of scarce resources by assessing the shortfalls between needs and resources available to disadvantaged people, ensuring that cost-effective packages of care are devised and coordinated, and regularly reviewing priorities. Needs identification is singled out as being of particular importance.

> *Unless those charged with responsibility for meeting needs are reasonably sure that they have a good knowledge of the major needs in their area, and of the individuals who have those needs, they can have no assurance that their policies and actions focus the resources they manage on the individuals in greatest need* (para. 3.9).

The case management task or social care planning role — to assess needs, determine priorities and formulate plans — provides the legitimacy for the quintessentially *public* face of social services. These responsibilities have important implications for social service departments, which should make the 'maximum possible use of voluntary and private sector bodies to widen consumer choice, stimulate innovation and encourage efficiency' (para. 1.3.4).

Local Collaboration

Notwithstanding the particular responsibilities placed upon local authorities, Griffiths recognises that collaboration between all local agencies — public or private — is essential to the development of effective community care provision. In particular, health authorities and social services departments will still need to work closely together. The starting point for a new partnership is that clear separate but complementary responsibilities need to be established between district health authorities (DHAs), social services departments and family practitioner committees (FPCs). The guiding principle is that DHAs and FPCs should have their role limited to that which is unambiguously health, even though this is not adequately defined. All sectors must be clear about their own responsibilities even though joint planning between separate agencies will be necessary on many occasions.

Two aspects of Griffiths' proposals are particularly important in this context. First, social services departments will be restricted in their capacity to undertake unilateral action. There will be 'a new requirement that collaboration and action are present normally as a condition for a grant' (para. 27). Second, Griffiths emphasises that organisational structures have to be adapted to the *local situation*; 'there is room

for infinite experiment' (para. 32). The recommendations do not preclude the establishment of a lead authority by agreement at local level. But to make a lead role mandatory would be premature and over prescriptive.

Finance and Specific Grants

Public finance for community care is largely provided at present through social security, health and local authority programmes. The detailed recommendations in the Griffiths Review would require some changes in the allocation of exchequer-financed resources to provide a specific grant to local authority social services. Subject to a centrally-determined ceiling, a substantial proportion of spending on community care would be provided via a specific grant on condition that local plans for service provision met with the approval of central government. It is intended that spending could exceed the ceiling provided the whole balance of resources could be found locally. But it is assumed that a specific grant would provide a positive incentive to improve community care provision in under-provided areas. In addition to the general grant, targeted specific grants may be appropriate in specific circumstances eg. long stay hospital discharge programmes.

The principal rationale for a general specific grant is:

- to recognise the interdependence of local and central government programmes
- to provide a degree of central government influence and control
- to create a more stable basis for planning and delivery of services
- to ensure transferred funds reach their intended destination (para. 5.14).

The precise basis upon which the specific grants should be distributed to local authorities is not set out in the Review. However, it is made clear that any formula should reflect both differences in needs and resources between areas. The needs indicators developed by the Personal Social Services Research Unit at the University of Kent (Bebbington and Davies, 1980) might be the best starting point for an equitable distribution. But a formula for grant allocation in the 1990s must take account of changing circumstances, including general economic and social trends. For example, Griffiths suggests that changing patterns of income and wealth amongst the elderly population increases the potential to expand the contribution of charges for social services. The Review recommends that the needs indicators for the distribution of the community care specific grant between social services authorities should include a factor reflecting the average ability of the consumers of social services to pay economic charges.

Residential Care

In one of his most far-reaching proposals, Griffiths proposes that anyone applying for public assistance for residential care should be subject to the same financial and needs assessment regardless of the type of home they wish to enter.

> *The separate funding of residential and nursing home care through social security, with no assessment of need, is a particularly pernicious split in responsibilities, and a fundamental obstacle to the creation of a comprehensive local approach to community care* (para. 4.21).

Public finance rules for residential home care or non-acute nursing home care in the public, private and voluntary sectors should be the same. A residential allowance will be payable by social security where it is satisfied that an assessment of needs and income has properly been carried out. But this allowance will be limited to 'the average total of income support and housing benefit to which someone living other than in residential care would be entitled' (para. 6.42). The remaining costs of residential care provision will be met by the social services department where it is satisfied that this is in the person's best interests and subject to locally determined priorities. People who can afford to do so will be expected to contribute to the cost of residential care.

The distinction between residential care and non-acute nursing homes will be removed. All homes in the public, private and voluntary sectors — including those outside the present framework — will be regulated in relation to their stated objectives; standards should be consistent across sectors.

Financial savings which arise in the social security budget will be transferred to local authorities. However, an increase in residential provision in the public sector will be discouraged. Social services departments will be encouraged to develop new forms of partnership with the private and voluntary sectors.

Future Pluralism

The pace of social and economic change is so great that any proposals for reforming the provision of community care run the risk of dealing with yesterday's problems. Griffiths is conscious of this danger and advocates positive encouragement being given to experiments to develop new kinds of services. In doing so, he echoes some of the arguments advanced in the White Paper, *Growing Older*, published in 1981.

The White Paper emphasised that the role of the state in meeting the needs of elderly people will have to change to 'an enabling one, helping people to care for themselves and their families' (para. 6.10). It is argued that the public expenditure implications of maintaining existing policies and standards of public provision are so considerable that radical changes in the development of social policy are in need of urgent consideration.

> *The increasing needs of increasing numbers of older people simply cannot be met wholly — or even predominantly — by public authorities or public finance. This will be a task for the whole community, demanding the closest partnership between public and voluntary bodies, families and individuals. The framework of co-operation has to be developed now* (para. 9.6).

There are a number of ways of responding to this injunction and Griffiths does no more than indicate the possibilities in very general terms. These include social/health maintenance organisations and other forms of social care insurance. He also suggests that corporate financial planning in future years may reflect growing concern about community care in the way that support for occupational pensions developed after the second world war. But there may also be a case for action to be taken by government to lead the way.

> *More immediately there is no reason why, on a controlled basis, social services authorities should not experiment with vouchers or credits for particular levels of community care, allowing individuals to spend them on particular forms of domiciliary care and to choose between particular suppliers as they wish* (para. 39).

Implementation

If the package of recommendations is accepted a considerable programme of work will be required to define and then manage the detailed changes necessary. Many of these changes need legislation. An early priority for a new Minister of Community Care, therefore, is the establishment of a high-powered team to supervise the complex process of change. Griffiths suggests there are two primary tasks:

> *first, securing the necessary climate for implementation of the general approach and second establishing and monitoring an implementation programme* (para. 7.2).

Resources

Griffiths emphasises that his 'remit is not to deal with the level of funding but rather to suggest how resources may better be directed' (para. 7). Obtaining better value for money is the primary objective. But Griffiths is quite emphatic that 'the review is not about cost reduction' (para. 7), and he clearly appreciates the difficulties facing some social services departments. He proposes, therefore, to switch financial resources for community care to local authority social services from both social security and health authorities. Moreover, one aim of the proposed general specific grant is to ring fence the existing and transferred resources for community care so that they 'reach their intended destination' (para. 5.13)

More generally, Griffiths places a considerable burden of responsibility on the designated Minister who:

> *would be responsible for ensuring that national policy objectives were consistent with the resources available to public authorities charged with meeting them* (para. 6.21).

The report stresses that it is imperative that a reasonable balance should be struck between policy and resources. Ministers must resist the temptation to encourage policy developments without clearly indicating how they will be funded. Leadership and direction is essential. But it will be brought into irreparable disrepute if it proves to be empty-handed and rhetorical.

> *What cannot be acceptable is to allow ambitious policies to be embarked upon without the appropriate funds. On many counts poorly implemented programmes for change are very often worse than the status quo. Even with the improved machinery of handling and funding which are recommended, if we try to purse unrealistic policies the resources will be spread transparently thin* (para. 38).

MEETING THE CHALLENGE

Griffiths' proposals for the future development of community care have major implications for a variety of agencies and services at all levels of government and beyond. If the reforms are to stand any chance of being implemented as intended by their architect, the various agencies and professionals on which their fate largely hinges must be able, or equipped, to respond. In what follows, we assess the challenge involved in making a reality of the Griffiths recommendations at national and local levels, and present our views and suggestions about certain problem areas.

National Arena

Central Government

The proposals place major responsibilities on central government and on particular departments, principally the DHSS. Six issues are singled out for comment.

1. Statement of National Policy

The Minister for Community Care is called upon to provide a clear, unequivocal statement of national policy on community care in order to establish policy leadership. However, a statement of principles and objectives is of symbolic value only unless central government is able to demonstrate by its actions that it fully subscribes to them. A display of political will is necessary to secure progress. Wales provides a clear precedent here: without the unequivocal support of the former Secretary of State for Wales, Nicholas Edwards, the implementation of the All-Wales Mental Handicap Strategy would not have achieved the necessary momentum (Hunter and Wistow, 1987).

2. Inter-Departmental Cooperation

In its submission to the Griffiths Review, the King's Fund (1987) emphasised the importance of co-operation both within and between central departments. The Griffiths report reaffirms the importance of such co-operation within the DHSS. It is not clear, however, that the need for a joint approach *between* departments is fully appreciated. While commentators have concentrated on the problems of joint planning and working at local level, similar problems are evident at the centre although less attention is generally given to them (Challis *et al*, 1988).

If it is accepted that there is merit in encouraging local diversity and experimentation and that the task of central government is to ensure that what emerges from this activity meets the principles and objectives of community care policy, then the relevant central departments (eg DHSS, Department of the Environment, Department of Education and Science) will only be able to undertake this task effectively if their policies co-exist in reasonable harmony rather than, as is often the case at present, pulling against each other. For example, local authorities run the risk of being rate-capped at the end of the tapering period for projects supported through joint finance. The new community charge, which is being introduced in Scotland in 1989 and in England in 1990, will have implications for community care in situations where, for instance, someone is looking after an elderly relative in their own home.

At local level, many service managers, planners and providers are puzzled, confused and ultimately frustrated by contradictory policies emerging from different central departments. Continuing fragmentation at the centre is likely to hinder attempts by central government to give a lead to, and monitor effectively, the efforts made by local agencies to implement successfully a coherent strategy for community care. As the former Central Policy Review Staff (1975) cautioned in its report on a joint approach to social policy in the mid-1970s:

> *if a 'joint' and more coherent approach to social policies is to have any chance of succeeding, departments and ministers must be prepared to make some adjustments, whether in priorities, policies, administrative practices, or public expenditure allocations* (para. 13, page 5).

3. Monitoring Local Plans

A major task for central government which flows from the Griffiths proposals is the DHSS' responsibility to monitor and approve local plans. In many ways this proposal resembles the arrangements adopted by the Welsh Office in regard to services for mentally handicapped people (Welsh Office, 1983). The All-Wales Strategy is based on firm leadership from the Welsh Office coupled with flexibility over the way in which agreed plans are implemented locally. The Welsh Office approves joint plans submitted by local authorities (ie the lead agencies) in regard to services for mentally handicapped people. Under the Griffiths proposals, the DHSS will be expected to have similar responsibilities for all community care groups. This major new responsibility raises a number of issues. First, does the DHSS have the appropriate skills and staff to carry out an assessment of local plans for a range of care groups? Second, has it the capacity to establish criteria whereby it will be able to assess local plans and determine whether or not they are in line with central government thinking? Third, is the machinery likely to be forthcoming to enable the Department subsequently to ensure that agreed plans have been implemented? Given the resources at its disposal we do not doubt central government's ability to address these issues but we have strong reservations about its willingness to do so. This is why we put forward for consideration the proposal for a community care development agency (see below).

It is not simply a question of the centre monitoring local developments and seeking compliance. Although the Griffiths Review does not consider the issue, the DHSS should be encouraged to develop its capability for policy learning so that, where necessary, it can adapt its own thinking in the light of knowledge and experience gained at local level. In addition, as the Griffiths report recommends (see para. 7.6), the Department should have an important dissemination function promoting good practice and innovative developments across the country. Again, however, the question arises: does the centre currently possess the capability and, more important, the will to perform

such functions? If not, how can they be acquired or encouraged?

4. Assessment Criteria
Under the Griffiths proposals, local authorities will be responsible for undertaking assessments of all applicants to residential care whether public or private. At present there are no agreed assessment criteria — they vary markedly across various authorities. Unless an attempt is made to reach a consensus on the issue of standardised assessment procedures then it is quite possible that the chances of admission to residential care may lie, as is often currently the case, less in a person's need for that form of provision than in where that person happens to live. Such variation may be entirely legitimate and even desirable given different individual circumstances and the nature and availability of services locally. However, in the interests of fairness across the country, there need to be agreed limits on local discretion.

5. Grant Formula
The development of community care along the lines proposed by Griffiths means devising a formula for the distribution of a community care grant and possibly other mechanisms for the allocation of targeted grants. These grants will require to be based on needs indicators which, given current knowledge, remain somewhat crude and undeveloped. Improvements in these might profit from the formation of closer linkages between the central department and the research community engaged in such activity. In addition, in order to establish whether community care plans are operating effectively there will be a need to devise outcome measures, and to produce process evaluations, in order to establish the best ways of achieving the desired goals. The Secretary of State's current health index initiative represents a step in the direction of establishing outcome measures.

6. Implementation
It is suggested in the Griffiths Review that an implementation team be set up at the centre to translate and develop the general framework put forward in the report into specified machinery and plans. The locus of such a unit or implementation team would probably be the DHSS. But careful thought should be given to the size of such a team, its composition and its likely lifespan. For instance, is such a team to be made up entirely of Departmental officials, as Griffiths appears to envisage, or should there be scope for outside appointments? We strongly favour a mix of insiders and outsiders. Attention also needs to be given to setting a timetable for action and we fully endorse Griffiths' injunction in this respect. Unless these matters are resolved satisfactorily the likelihood is that any implementation team will be absorbed into Whitehall and fail to drive forward the reforms.

Careful attention will need to be given in the implementation phase to the transitional arrangements envisaged in the expanded role for SSDs and the diminished role for health authorities. Rightly or wrongly, many of the developments in community based services in recent years have been health led. If this activity is no longer deemed to be legitimate for health authorities then they may well feel under no obligation to continue and develop their community care work. 'Planning blight' must be avoided if services are not to become further impoverished before they can advance. Such an outcome would be worse than the present arrangements and would amount to a travesty of what is intended in the Griffiths report.

The implementation of the reforms poses problems for other parts of the UK — Wales, Scotland and Northern Ireland. Given that each country, including England, is starting from a different service base and from a slightly different policy position it may be necessary for the DHSS implementation team to have counterparts in the Welsh, Scottish and Northern Ireland Offices. First, however, the respective Secretaries of State in each of the four countries must decide whether or not they endorse the Griffiths report.

Regulatory Agencies

As we have noted, the Griffiths proposals place considerable emphasis on the need for effective monitoring of plans and services in order to ensure the implementation of effective community care. At present there are a number of agencies with some stake in the monitoring and dissemination of good practice. These comprise the Health Advisory Service, the National Development Team for the Mentally Handicapped, the Mental Welfare Commission, the Social Services Inspectorate and the Audit Commission. The activities of these bodies overlap in the context of their involvement in community care services. A clarification of their respective responsibilities is necessary in order to maximise their impact.

Allied to this suggestion there might be a case for establishing a single national inspectorate for all community care services. A case for such a body was made some years ago by Klein and Hall (1974). Alternatively, there might be scope for establishing separate inspectorates for the four main client groups — the elderly, the mentally ill, the mentally handicapped, and the physically disabled. A model for this already exists in the form of the National Development Team.

Whatever machinery is devised in order to meet the obligations set out in the Griffiths Review to ensure the regulation of community care services, there will be important work to be done in the area of disseminating good practice and also, and perhaps most important, facilitating and promoting the take up of new ways of operating. Quite often, the problem is not so much one of lack of information on what might be done but practical advice and support in actually getting that information acted upon. We suggest below that this might be a responsibility of a Community Care Development Agency.

Local Arena

Social Services Departments

If the Griffiths reforms contain major challenges for the way in which central departments operate, they are no less significant for local authority SSDs. We comment on four in particular.

1. Social Care Planning

If social services managers are increasingly asked not so much to provide services but to fund and package them from a variety of sources to meet an individual client's needs, then this suggests very different skills and abilities from those traditionally associated with social work management. As the Barclay (1982) report noted, social services departments have failed 'to develop overall plans which link the voluntary, volunteer, statutory and private services in an area into a coherent plan' (paragraph 3.21). The notion of social care planning is aimed at tackling this problem. SSDs 'need to discover and bring into play the potential self-help, volunteer help, community organisations, voluntary and private facilities that exist' (paragraph 3.23).

A major organisational and management development task will be the preparation of existing social services departments and managers for the new roles envisaged for them and to ensure that they are equipped with the appropriate skills (see Griffiths report, para. 8.6). Whether the responsibility lies with the Central Council for Education and Training in Social Work, the Local Government Training Board or elsewhere will need to be determined. Moreover, although the Griffiths report declines to mention them, organisational and staff development will incur costs which will need to be met from some source, perhaps a development fund top-sliced from the specific grant. Care will need to be taken to protect service budgets from erosion for such purposes.

A related challenge concerns the kind of people necessary to perform the tasks set out in the Griffiths Review (see para. 7.8). For instance, how appropriate are traditional social work skills? If they are no longer sufficiently appropriate what skills should complement or replace them, and how far is it the case that existing social services managers would want to acquire them?

2. Organisation of Social Services Departments

A major issue is the ability of SSDs to respond to the challenges outlined in the Griffiths Review. The Seebohm Committee (1968) proposed 'a community-based and family-oriented service' in order to establish the principle of 'single-door' access to a range of services. The Griffiths Review broadly supports this notion. However, in practice most SSDs focus their resources on, and positively discriminate in favour of, child care and family services, which is where their main statutory obligations lie. The needs of those who fall into the so-called priority care groups often go by default. As a consequence, the advocacy role of social workers in regard to, for example, older and physically disabled people is often weak. Is there a case, therefore, for advocating more specialisation within SSDs between child care and family services on the one hand and community care services on the other? Obviously, it would mean a move away from the notion of generic social work but there is evidence from many authorities across the country that greater specialisation is already a reality (see Challis and Ferlie, 1988). Moreover, if there is to be a specific community care grant then it makes sense for SSDs to be organised in a way which best facilitates its allocation. Several permutations are possible and it is not our purpose to be prescriptive. For instance, one option would be to encourage greater specialisation within existing departments. Another would be to split departments into two: a child and family welfare department and a community care department.

SSDs are part of local authorities which have many functions to fulfil and while they occupy the most important position in regard to community care services other local government departments, notably housing, also have a major role to play. We comment further on this issue below but it is important to point out that within local authorities there is a need to establish priorities not merely within SSDs but also between departments within a local authority.

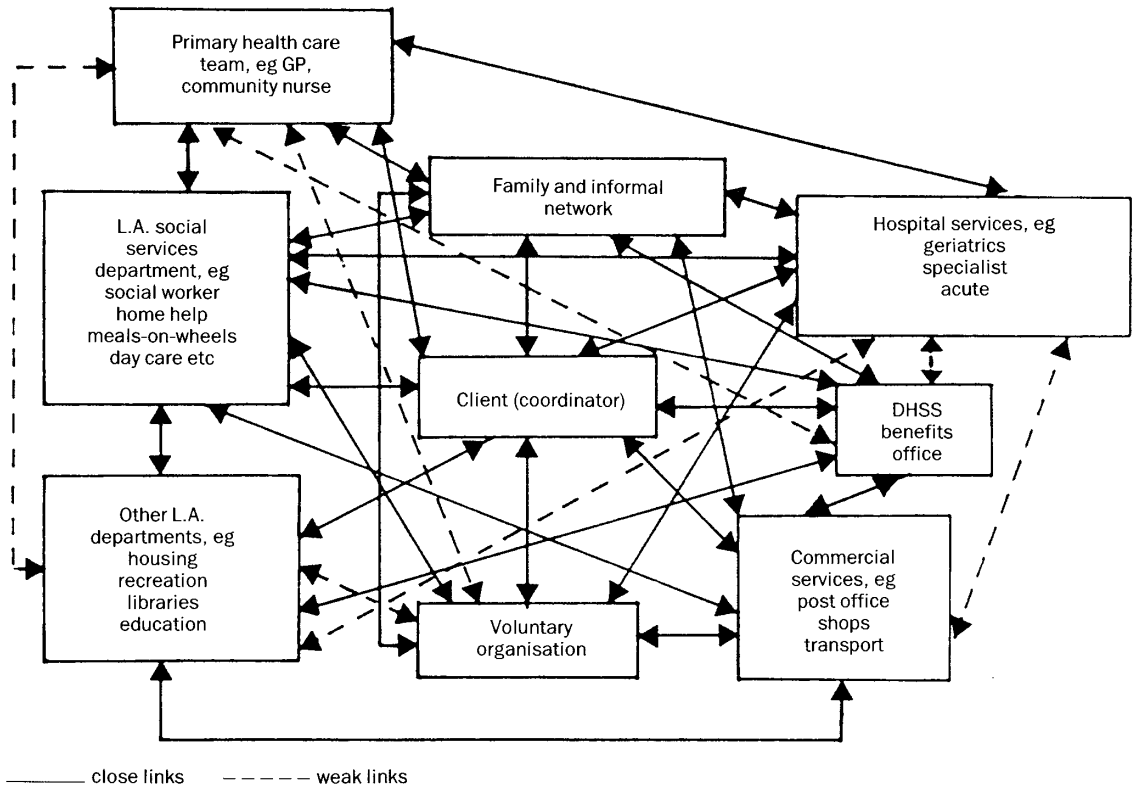
A further area of concern for SSDs will be the development of case management skills and responsibilities in order to offer coherent and coordinated services to individuals that closely match their needs (see Figure 2). There are, of course, several examples of successful case management schemes in operation in different departments, notably the Kent Community Care Project (Challis and Davies, 1986), but these tend to remain 'add ons' to mainstream provision. In the aftermath of Griffiths a priority will be applying the concept of case management more widely. Again, this has major implications for management development and training.

One of the problems with the term 'case management' is the multiple meanings attached to it (Hunter, 1988). In particular, there is the client advocacy role versus the allocating and management role. While there need not be a tension between the two dimensions, in practice there could well be. From the perspective, say, of government and service managers cost containment might be more prominent in their support for case management than advocating the preferences of individual service recipients. It is not entirely clear what role Griffiths sees the case manager performing since it is only fleetingly mentioned. However, it is likely that he sees their principal responsibility as being to make the best use of available resources. Nevertheless, it is not difficult to foresee the potential for conflict between client advocacy on the one hand and resource management on the other. There are no simple or single answers to such matters — each locality must arrive at the solution which most closely accords with its preferences and/or needs.

3. Innovation in Service Delivery

A major challenge offered to SSDs by the Griffiths Review is the encouragement to them to innovate and organise community care services in very different

FIGURE 2 · THE COORDINATOR'S NIGHTMARE



SOURCE. A Norton, B Stoten and H Taylor, Councils of Care, *Centre for Policy on Ageing, London, 1986.*

ways from those presently in existence. For example, there would be scope for departments entering into consortia arrangements with other agencies in order to provide comprehensive services at local level. Another option is the creation of cooperatives in which users and/or their carers might assume responsibility for providing services perhaps in partnership with providers. There might also be scope for the organisation of community care services on a patch-based, case management agency model whereby those within SSDs establish not-for-profit agencies to provide community care. This might be thought of as analogous to a management buy-out whereby social work managers themselves would take on the responsibility for providing services. They might then compete with more orthodox public bodies providing community care in order to offer choice and variety to users but also to experiment with new ways of delivering care. They might, for instance, combine advocacy, assessment, awareness and allocation functions. They would not directly provide services but would have a responsibility to report annually on the social care needs of their areas.

Whatever the form of service delivery systems that actually emerge, there is a clear implication in Griffiths that SSDs should adopt a more entrepreneurial approach to what is described in the USA as purchase of service contracting (POSC). This poses a particular challenge for SSDs, because if POSC is not carefully developed it will both increase costs and reduce effectiveness.

> *If POSC is to be a strategic instrument of public policy in the field of British social care then SSDs must do three things. First, they should clearly specify their objectives in some form of written contract. Second, they must develop a set of carefully designed fiscal incentives to influence the supply response of actual and potential providers. Finally, they need to monitor and evaluate the performance of suppliers so as to ensure contract compliance, and to modify incentives in the light of practical experience* (Judge, 1982).

4. Monitoring

The development of services locally and the encouragement of diversity and pluralism demands the introduction of a monitoring capability to ensure that standards are maintained. This would require an extension of the present monitoring procedures in regard to residential care. Again, this obligation on local authorities carries with it manpower and staff development implications. As part of monitoring, SSDs

might be required to produce annual reports detailing progress in implementing community care policy.

Other Agencies

Apart from SSDs, a number of other local agencies are active in the planning and provision of community care. The most important of these are health authorities, family practitioner committees, housing departments, voluntary organisations and private organisations. The major challenge for these bodies posed by the Griffiths proposals is one of realignment.

(a) Health Authorities

At present, health authorities often tend to be the leading actors in regard to community care developments at local level through the joint planning and joint finance machinery. Of course, where local authorities are happy with a health authority, or authorities, performing a predominant role then there is nothing against such arrangements continuing provided that central government is satisfied that they comply with nationally determined policy. However, in most cases (and particularly if joint finance is transferred to SSDs as Griffiths proposes) it is expected that there will be a major shift in the balance of power from health to local authorities in regard to the future development of community care. The move will have implications for those providing services for priority groups within DHAs, in particular the managers of priority services and their newly-formed management units. Attention will need to be given to transitional arrangements to minimise disruption both to clients and staff morale. In particular, as we pointed out earlier, if health authorities are to lose control over facilities and services, steps may need to be taken to avoid a situation whereby these are allowed to deteriorate prior to the introduction of new management arrangements. There will, of course, continue to be a need for joint planning between agencies at local level and it will be up to such agencies to decide what machinery to retain, or establish, to ensure its future. If SSDs are to become the lead agencies in developing plans for the priority groups then attention will need to be given to their relationship to DHA planning mechanisms. The most appropriate solution, favoured by the Griffiths report, is the production of joint plans between SSDs and health authorities (para. 6.16).

One of the major areas of concern in the Griffiths Review relates to the feasibility of being able to establish clear boundaries around what is ostensibly a health service responsibility and what is a social care responsibility. To all intents and purposes, Griffiths is suggesting that the NHS be concerned with explicitly health needs while SSDs concern themselves with social care needs. The problem is, of course, that many individuals in the priority care groups, particularly elderly and physically handicapped people, move back and forth between health and social services depending on their changing circumstances.

Increasingly, health services, particularly those in the community health sector, operate on an outreach basis whereby services are provided to people living in their own homes. There are demarcation issues to be addressed, if not resolved, between the activities of, for example, district nurses, community psychiatric nurses, health visitors, social workers and home carers. These are not just agency problems but touch on sensitive issues of professional self-definition. Problems of inter-professional joint working have been a major cause of frustration in community care for some time. Setting agreed and fixed boundaries around what constitute health responsibilities and social services responsibilities, and establishing where the different roles of the various professional groups fit in to this division, will not be easy. It may be that ultimately the solution will lie in the development of a new type of professional role, the community care worker, who attempts to remove the unnecessary duplication and overlap which is a feature of the current fragmentation among professional groups.

In regard to joint finance, it is not clear how it is proposed to transfer this allocation to local authorities. The complexities of the mechanism and its tapering arrangements will need to be examined carefully if a shift is to occur painlessly.

(b) Family Practitioner Committees

The gatekeeper role of general practitioners (GPs) is clearly recognised as important in the Griffiths report. It is suggested that a duty be placed on a GP to notify the SSD of a patient's possible community care needs (para. 6.14). Indeed, the report goes further than the recent White Paper on primary health care which has little to say on priority groups and referrals outside the acute sector. What the standing of the Griffiths proposals is in the light of the White Paper is not clear. Nor is it clear from the White Paper or from the Griffiths Review what the relationship should be between the primary health care team and the new style community care services. If GPs are important channellers of patients to different forms of provision then there are implications here for the training and development of GPs and in particular for their relationship with SSDs. The preference in the Griffiths report for more shared training to overcome professional insularity merits close attention (para. 8.8).

(c) Housing Departments

The Griffiths report proposes a narrow 'bricks and mortar' role for housing departments (para. 4.9). However, many departments have adopted a wider view of housing in community care and have been active participants in joint planning forums. If there has been a criticism of housing departments it is that in general they have not been sufficiently involved in social care planning. There is a danger that in circumscribing the responsibilities of housing departments their commitment to community care may become weaker at a time when it needs to be strengthened (National Federation of Housing Associations and MIND, 1987).

(d) Voluntary Sector

The voluntary sector is already performing a major role in the active provision of services. Under the Griffiths proposals it is expected that such a role will expand.

Voluntary organisations can increasingly expect to become service providers. This poses particular challenges to the voluntary sector because hitherto there has been some internal disagreement about what its role should be (National Council for Voluntary Organisations, 1987). Should voluntary organisations substitute for formal statutory services or should they be seen as complementing such services: able to act in a nimble footed way so that they can experiment, innovate and point the way to new ways of providing care to individuals? Are voluntary bodies able to offer the stability and consistency over time required in service provision?

(e) Private Sector

The role of the private sector can also be expected to grow in importance. The challenge here is one of the need for diversification. It is not simply a case of the private sector being confined to residential care and doing 'more of the same'. There is scope for the sector to develop sheltered housing, day and domiciliary care services offering home nursing, home caring and so on. Whether the private sector is in a position to respond to this challenge and meet the opportunities which may be opened up is arguable. It is likely, in any case, that such activity will be highly variable across the country. As we suggested above, there may also be scope for a new breed of non-profit community agencies to provide services.

If the private sector does grow and diversify into new areas of activity, then issues of service quality and standards will loom large and will need to be addressed by SSDs.

The Case for a Community Care Development Agency

There must be some large question marks over the capacity and ability of central and local government to adapt to the challenges set forth above. A major shift in thinking and practice will be required in order to secure progress along any of the dimensions that have been mentioned. In particular, changes at the centre may be necessary to facilitate the implementation of the Griffiths reforms. The government has begun to slim down the central policy-making capability and hive-off executive functions of the civil service to semi-autonomous agencies. As part of this reform strategy, we believe there may be scope for establishing a Community Care Development Agency (CCDA).

The agency would be directly accountable to the Minister of State for Community Care, which is proposed in the Griffiths Review, and would combine regulatory, monitoring and review functions with developmental ones. It would also have access to limited pump-priming funds to stimulate and facilitate innovative developments at local level. Of course, there is already a great deal of innovative practice at a local level. The challenge is to encourage successful one-off initiatives to become part of mainstream provision and to promote their spread across other regions in other parts of the country. A Community Care Development Agency could serve as the ideal vehicle to take on this role. Clearly, the nature and operation of such an agency requires much more detailed scrutiny.

The idea for a development agency in the NHS to promote innovation is not a new one and has received considerable attention (Royal Institute of Public Administration, 1981; Ham and McMahon, 1982). Many of the issues arising from this discussion are of continuing relevance to a CCDA. In particular, the agency would combine a top-down with a bottom-up perspective. It would not act as a heavy-handed compliance-seeking arm of central government but would serve as an advocate acting on behalf of SSDs in central government. Its chief strength would lie in helping to establish a dialogue between central and local interests. The importance of this should not be under-estimated. Mutual trust between the two tiers of government is essential. Both must have confidence in the roles assigned to each other. Griffiths cannot be successsfully implemented in a climate of suspicion. Central government must reduce its excessive paranoia about local authorities. For its part, local government ought to seize the opportunities presented by Griffiths rather than exaggerate the threats.

Resources

The Griffiths proposals add up to a substantial confirmation of and increase in the social care responsibilities of local authorities. This will please some and cause concern to others. But if the recommendations are implemented, the most important questions to be raised by those given the responsibility for action will concern resources. Are they sufficient? Will they be protected? What choices will have to be made?

There is scope for using the £6 billion currently devoted to community care more efficiently and creatively. Griffiths' framework is designed to enable this to happen. At the same time, with rising demands brought about by demographic and social trends — in particular the increasing number of very old people aged 85 and over and changes in family structure — it has to be recognised that additional resources will be required if community care services are to cope with the extra pressures. Otherwise, community care will remain, in Griffiths' terms, 'a poor relation'.

CONCLUSION

The main purpose of this paper has been to appraise the Griffiths proposals in the light of both the widely accepted critique of existing arrangements, and the challenge they pose for the principal agencies involved in the business of managing and providing community care. The central issues are summarised in Figure 3. There are a number of major challenges to be met and it will be the task of the implementation team proposed by Griffiths to establish a clear timetable and set of priorities to enable the work to proceed in a feasible and systematic manner.

The key underlying principle governing the development of community care is to increase the availability of appropriate and flexible services whenever and wherever they are needed. In order to realise this goal, more and better-used resources will be required, but there are other pervasive issues that also require attention. In particular, there is the problematic issue of setting clear boundaries around health and social care responsibilities respectively. It is hard to see how these can be defined with any precision. Those that are established will certainly

FIGURE 3 • CRITERIA FOR ASSESSING GRIFFITHS

ISSUE	Policy on Community Care	Levels of Responsibility	Monitoring and Policy Learning	Organisational/ Financial Incentives	Consumers/ Users	Staff Training and Development
THE PROBLEM	Confusion about objectives; lack of clarity concerning principles; mixed messages received by local agencies; need for clear, shared, well articulated policy goals.	Three levels: national, local, street. Each level raises different issues and problems which are often not made explicit.	Roles of various agencies; HAS, NDT, SSI, Audit Commission. Need for monitoring and policy learning to link in with policy objectives.	Social security B & L payments are a perverse incentive. Organisational fragmentation.	Enabling consumers to find their way around services more easily. Support for carers.	Determining appropriate skill mix; recruitment and career development; staff transfers; brokerage roles for social services managers.
ACTION PROPOSED	Central government to give policy leadership and articulate coherent policy; policy not just about the rundown and closure of LS hospitals.	Clarification of issues and responsibilities of these levels; strategic, monitoring and facilitating roles for centre; lead agency role for SSDs.	Enabling and monitoring roles for centre.	Centrally determined specific grant plus top-sliced grants for particular initiatives (eg hospital closures); B + L payments problem addressed. Scope for case management and key worker schemes.	Key workers; client advocates; case managers.	Multi-purpose community care workers with limited training.
AREAS OF CONCERN	Is the political will present? Do central departments possess the necessary capability?	Inter-departmental relations at national level. Case for a CCDA. Can SSDs function as intended?	Appropriate mechanism to disseminate good practice. Is there a case for a single national inspectorate to replace existing multiple agencies?	Establishing formula for community care grant. Future of joint planning and finance. Role of centre in assessing local plans. Can assessment criteria for residential care applicants be standardised? Should consortia/ partnership schemes be encouraged?	Balancing the advocacy role with the allocating and management role.	Real commitment to organisational and management development. Responsibility for training. Resolving inter-professional disputes.

need to be highly permeable to allow effective interchange between providers operating at the frontline of the health and social care interface. Case management may assist in this liaison process.

A second major issue which arises from the Griffiths agenda for reform is the need for fundamental change in the thinking and practice of many people currently planning, managing and providing services at both national and local levels. It amounts to nothing less than a cultural revolution. The implications of this for new staff recruitment are not immediately apparent. In most instances, however, it must be a case of developing new skills among existing staff to enable them to tackle the new tasks proposed. There may even be a case for developing completely new roles and replacing those that no longer appear to be necessary. Careful attention needs to be given to such issues if there is not to be wholesale opposition to the proposals and if staff are not to feel unduly threatened. The personnel dimension will need to be managed sensitively if morale is to be maintained during what might be a period of considerable turbulence.

In recent years, relations between central and local government have been severely strained. Progress is dependent on the establishment of a better understanding on both sides. If this can be achieved there are many exciting opportunities waiting to be grasped. Encouragingly, the Griffiths Review does not offer a blueprint and nor does it prescribe in detail how the challenges that it presents should be met. Instead, it sensibly offers a coherent framework within which those responsible for managing and providing care can do so in such a way that their abilities and skills are exploited to the full. There is no one best way of providing community care. There is no 'quick fix' to the professional, managerial and organisational complexities posed by attempts to assemble coordinated and flexible packages of care. The Griffiths report does not pretend that the way forward will be easy. But it acknowledges that there are numerous examples of successful achievement and attempts to offer a framework designed to facilitate the generalisability of these isolated innovations. The framework proposed offers the exciting prospect that such schemes might eventually be the norm rather than the exception.

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