King's Fund

MAKING A DIFFERENCE TOGETHER

Reflections on the King's Fund as a Health Sector Development Agency

DAVID TOWELL

Contents:

King's Fund
11-13 Cavendish Square
London W1M 0AN

Introduction

Over the twenty years since joining the King's Fund in 1978, I have had the tremendous privilege of working with large numbers of people - in government, public agencies and community groups - as they have sought to make a positive difference in peoples' lives: that is, in the words of the title for this collection, we have been *making a difference together.* While not the only way the Fund seeks to pursue its mission, I believe that this willingness to work in partnership with the people and agencies who hold the public responsibility for improving health and well-being is a core role of a modern foundation and central to the identity of the Fund as the major independent health sector *development agency.*

In my own case, this contribution has involved a wide variety of discrete pieces of work with different people in different places, as suggested by the appended list of publications. However, running through almost all these endeavours have been one or more of three main objectives:

- improving 'community care' i.e. ensuring that people with long-term illnesses and disabilities have the opportunities and support necessary to enable them to live full lives alongside their non-disabled fellow citizens;
- modernising London's health system i.e. finding better ways both locally and across London of addressing health inequalities and achieving large-scale change in the patterns of services;
- developing strategic partnerships i.e. enhancing the capacity of multi-agency systems (e.g. from Primary Care Groups to Health Action Zones) to adopt a more holistic approach to tackling important problems with the involvement of relevant stakeholders.

Clearly the challenges defined by these objectives do not lend themselves to easy 'solutions'. Rather the work I have done with colleagues has required an appreciation of their complexity and continuously evolving nature, in which people are always struggling to find better ways of responding to current dilemmas. Correspondingly, our aim has usually been to work in ways which increase the capacity of individuals and organisations themselves to create positive change, so that they are better able to achieve continuous improvements in what they do. And it has been important to 'stick with it' over long periods so as to learn what really makes a difference and indeed what is required to make positive change sustainable.

To engage in such work with integrity and competence, it has been essential that Fund staff reflect seriously on what it means to be effective 'change agents', invest in developing appropriate approaches and skills, and seek to learn from feedback from our field partners.

This commitment to making the Fund itself a 'learning organisation' has been present at least since Robert Maxwell joined as Chief Executive in 1980 and particularly evident in the reinvention of the King's Fund College by Tom Evans and his successors during the years which followed. Relevant features of the new College - although these aspirations were not, of course, always realised - included the involvement of all

Faculty in pooling experience from different areas of work to shape corporate priorities, regular 'retreats' to review performance and explore potential initiatives, an emphasis on team working to bring together colleagues with different skills, and support to individuals to reflect on their own professional work through facilitated 'learning sets' and in other ways.

Whatever the particular content of these activities, six inter-related questions have been central to our efforts to establish a distinctive identity for the College-in-the-Fund and strengthen our developmental contribution:

- **Purpose** - What is the purpose of our work in the context of the Fund's overall social mission? How will the health sector be different through our efforts?
- **Values** - What values inform this work and our relationships with external partners?
- **Methods** - How do we pursue this purpose? Through what distinctive forms of intervention?
- **Ideas** - What concepts and theories enable us to understand the challenges we are addressing?
- **Environment** - What are the main issues arising in the development of health and well-being? What are the opportunities and problems being faced by relevant people and agencies in addressing these issues?
- **Impact** - And returning to the starting point, what can we learn from feedback and evaluation about the impact of our work?

Much of the dialogue around these questions is now available only in the memories of participants. However, partly because flip-chart and white-board recording are common tools of our trade and partly because some material was written up more systematically, quite a lot also got committed to paper. Indeed when packing up my own stuff for the move to King's College, I found at least three box-files full of notes on these topics, of which I was quite often myself the main author!

Sorting through this material and focusing on my own work, I have selected here seven contributions produced during the 1990s which seem to me to have continuing relevance. Certainly I have found them useful in thinking about the optimum shape of the Social Inclusion Programme I am to lead at King's. I think they will also be of value to others among my new colleagues struggling with how to enhance the Universities' practical contributions in the changing conditions at the turn-of-the-century.

Within the King's Fund, I suspect this collection may be of mainly historical interest: my impression is that developmental work of the kind described here is currently in at least partial eclipse as the Fund seeks to rationalise its activities. Even so, if its new programmes are to have real impact, for example, in tackling the causes of health inequalities in London or improving the care of older people, I hope that some of what we learnt about achieving strategic change will be soon rediscovered.

The seven contributions together cover all six of the key questions identified above. Three have previously been published in different places; three were circulated only within the Fund; the final entry is currently in press.

⇒ Starting with purpose, *Passion For Development* was written on behalf of colleagues as a contribution to consultation on the Fund's future identity and priorities, following the move to a single site in Cavendish Square and in anticipation of its hundredth anniversary. One vehicle for this consultation was a paper prepared by Fund Directors on its 'Modern Aims' which was seen by colleagues as based on a rather technocratic conception of Research and Development: my brief was to offer a positive statement of what the College might contribute to a more integrated and focused Fund-in-the-future through combining independence and modesty with genuine *practical engagement.*

⇒ The two papers which follow explore values. *We Have A Dream* (with acknowledgments to Martin Luther King) was distilled from the flip-charts and post-its produced during an exercise I facilitated for Faculty colleagues at a retreat in 1990. Starting from reflection on the values we as individuals wanted to see characterise British society, we worked 'backwards' to a definition of the principles which should guide the College's work and our relationships with each other. Eight years later, this still reads quite well as an orientation to action in the 'new' Britain.

⇒ *Revaluing The NHS* (prepared for a seminar celebrating the 21st birthday of the Bristol School for Advanced Urban Studies) is a more detailed attempt to show how important values which should inform the organisation and practice of health care can be identified through reflection on personal experiences of health and illness.

⇒ Turning to methods and ideas, *Clarifying The Nature Of Our Professional Practice* was my contribution to a wider exercise in which colleagues tried to make more explicit the assumptions underpinning our work: this piece traces how my commitment to what Gareth Morgan calls *collaborative action learning* emerged from a particular intellectual biography and identifies some of the key texts I have found helpful in understanding health sector development.

⇒ Ideas, and their application to the complex challenge of change in London's health services, are the focus of the next contribution, which also considers what we have learnt about the environment for change from the work of the second King's Fund London Commission. *Transforming London's Health System* was written as part of a book marking Robert Maxwell's retirement from the Fund. It suggests how modern organisation theories might illuminate the new government's task (in partnership with local agencies) of bringing about the changes in provision required to meet the diverse health needs of Londoners into the 21st century.

⇒ Throughout the twenty years, a major focus of my own work, and one of the areas in which the Fund has had the most significant social impact, has been the promotion of *An Ordinary Life* for people with learning disabilities. The most sustained national initiative to this end has been the 'All Wales Strategy' in which the Fund was a continuing influence. '*Towards A Full Life*' is the report on a fifteen year evaluation of this Strategy. My *Foreword* traces the relationship between Fund innovation and national action and draws attention to the radical challenges still to be

faced in delivering on our commitment to people with learning disabilities and their families.

Finally, *Social Inclusion And Community Care* offers a programmatic statement on my new role at King's College, where I hope the best of what we have learnt over the last twenty years will inform the way we work with old and new partners to address the great challenge of building a more inclusive society: particularly in this context, the inclusion of people whose exclusion is associated with long-term illness or disability.

David Towell

King's College/King's Fund
September, 1998

PASSION FOR DEVELOPMENT

1 INTRODUCTION

1.1 It is in the very nature of the King's Fund that we, our trustees and those we exist to serve should always be questioning how the stability and tradition which are the essence of a century old charity with our unique patronage can effectively be combined with the innovation and renewal which are equally essential to ensure the continuing relevance of our contributions in a rapidly changing world.

1.2 Viewed in retrospect, we believe that the last twenty years - dating say from the opening of the King's Fund Centre in Camden Town - will be regarded as an excellent example of change through evolution. In this period each of the Fund's main functions (Grant-making, College, Service Development, Information Services) has been reshaped and revitalised, while new elements have been added to our capacities (Policy Analysis, Organisational Audit) which make the Fund unique in the potential strength of its developmental contribution. These achievements, set in the context of the longer heritage best represented in the reputation of the King's Fund itself, give us a tremendous base on which to build.

1.3 Now, the move to Cavendish Square, bringing all the Fund's parts together for the first time in 50 years, the symbolic significance of the Centenary and the need to find a new Chief Executive offer an important opportunity for further growth. Even more important than these 'internal' changes we would suggest are the external challenges which require us to review and renew what we offer: the trends which provide the context for health care development into the next century; the current state of the NHS and other public services; wider changes in British society in a shrinking world; the hopes and fears associated with entering the new Millennium.

1.4 Within the Management College, we are keen to participate actively in the current processes of dialogue and action which Robert Maxwell has initiated. In producing this paper we have tried to give prominence to our identity as part of the Fund, rather than as one of the Fund's parts. At the same time, in restating our *passion for development*, we have sought to articulate what the College might particularly contribute to a more integrated and more focused Fund-in-the-future.

1.5 As we have engaged in this internal process of reflection and the wider cross-Fund discussions which have followed circulation of the 'Modern Aims' paper, two sets of themes have emerged which inform the rest of this paper.

1.6 We recognise the importance of the period to July 11 when the Management Committee will be asked to give a steer for the future, in the light of the submission being prepared by the Chief Executive. Indeed we think that our trustees need to be fully involved in creating the conditions for future success. However all our experience of helping organisations adapt to a complex and

changing environment suggests that the future needs to be discovered and created, not simply prescribed; that success depends on working with the tensions between different perceptions and activities, not losing them through synthesis; and that therefore *this period needs to be used to mobilise a continuing and more effective process of engagement between trustees, staff in different parts of the Fund and external interests designed to sustain the impulse for renewal.* We have also come to the view that there is no contradiction between evolution and radical reform. Indeed we are tempted to the view - borrowing a little here from Sir Roy Griffith's famous dictum - that nothing could be more radical than that we concentrate over the next few years on doing better what the Fund already aims to do well in fulfilling its social mission.

1.7 As we have reflected on the type of analysis and many questions in the 'Modern Aims' discussion paper, we have also realised that these questions need to be ordered or reframed in the context of three more fundamental questions:

(i) What is the distinctive role and identity of the King's Fund as we approach the 21st century?
(ii) What is the nature of the Fund's relationships to the environment in which we seek to make this distinctive contribution?
(iii) What have we learnt about how an agency like the Fund really can enable valued development?

We have also come to the view that the discussion of 'Modern Aims' has been pitched too abstractly. Rather we believe that in the light of responses to these fundamental questions, the Fund should be trying to identify - and set out for public discussion - a limited number of important contemporary *challenges* which will be the main focus of its corporate contribution in (say) the next 3-5 years (building here on what has already been done over the last two years to identify cross-Fund themes).

1.8 In what follows, we develop this framework and use it both to suggest some ways in which the Fund's contribution might be strengthened and to offer responses to the concrete questions raised in the 'Modern Aims' paper.

2. THE FUND'S MODERN IDENTITY

2.1 We have already emphasised the importance of both continuity *and* change to the Fund's history and its efforts to remain relevant through changing times. King and Parliament (and the way they are currently reflected in the overarching trusteeship of the Fund) are part of that continuity, as is the commitment to protect the capital upon which the Fund's 'own' income depends.

2.2 The second essential strand of the Fund's identity, combining continuity and change, is its original and evolving set of purposes for the use of this income. Here we agree with the 'Modern Aims' paper that these purposes now need to be understood as concerned with promoting the health and well-being of Londoners, particularly through the intermediate goal of improving health care and related services. We agree with Andy Kennedy's interesting contribution that London in the 21st century needs to be seen as both diffuse geographically, and affected by national , European and inter-national forces which are therefore

legitimate topics for Fund attention. We also argue later that the capacity of the Fund's institutions to assist London cannot be based - for the most part (i.e. perhaps Grants excepted) - on a reputation for *only* working in London.

2.3 In the modern world however, grant-making Trusts cannot define their identify only in terms of history and purpose; they must also reflect on how best to pursue their goals. It is our view that a unique strength of the Fund, at least among Trusts working in health care, and therefore its third most important source of identity, is the way it has sought to combine its independence and integrity with *practical engagement* in the field of its mission. We understand that movement in this direction is a significant part of contemporary thinking among Trusts more generally - based in part on recognition of the weakness of grant-making as a 'single club' strategy in a world where both big government and big industry (and now the National Lottery) dwarf the financial leverage of even the biggest charities.

2.4 To the great credit of earlier generations of Fund trustees and senior staff, the King's Fund long pre-dated this movement. From the earliest days, the Fund used its status and the influence of its 'volunteers' to engage with other influential leaders to address London problems. For example, the Emergency Bed Service was a highly pragmatic response to war-time crisis, where a valued but independent agency could offer the base for a new problem-solving resource. Perhaps most far-sightedly, the historic Fund decision - with the nationalisation of the hospitals - to invest in institutions (originally the staff colleges, then the College, now the Management College) with the purpose of developing the leadership capacity necessary to deliver the new NHS in the public interest, marked the King's Fund out as a different kind of Trust; in the modern jargon we were the first - and now the largest - UK health sector *development agency*.

2.5 Creation of the College(s) and then the Centres (first, Hospital, then King's Fund Centre) had another important consequence for our modern identity. The College has always been more than a faculty providing learning opportunities: over forty years in which successive generations of both aspiring and senior leaders from the main health care professions shared 'King's Fund experiences', the 'college' has become an extensive network of committed people for whom the elegant Bayswater buildings provided a symbol of common membership - and in which the King's Fund is a key resource. The last two NHS Chief Executives, as well as a host of other leaders, are colleagues in this network. Equally the Centres came to offer more than 'one-off' conference facilities: the libraries are, of course, an educational resource to a myriad of individuals and the most significant programmes of work generated their own networks of mutual aid in which again the King's Fund was the most essential symbol and common link. For example, at its peak many hundreds of mainly middle-level professionals and local advocates looked to the King's Fund for moral leadership and support in working to achieve 'an ordinary life' for people with learning disabilities.

2.6 The move to Cavendish Square has probably disrupted at least the images of this kind of association but our new building - and its capacity to bring together different kinds of networks - offer the prospect of *renewing this sense of the*

King's Fund as a whole: as a support to mutual aid; a repository of relevant intelligence; and a safe forum for exploring contemporary concerns in ways which examine different views while seeking to counter the fragmentation which is arguably an endemic feature of the new arrangements for public services.

2.7 Consistent with the preceding points, but a further strength of the Fund largely established in recent years is the unique capacity to bring different kinds of perspective and method to the challenge of development - as currently expressed in the primary function of the Fund's five institutions. We are not convinced that this diversity is being used to optimum effect - precisely because of these institutional boundaries - but we do recognise the tremendous opportunity in Cavendish Square to mobilise these different capacities to shared ends, and we see, for example in the Fund's support to the London Commission and its role in the London Health Partnership, the seeds of future synergy.

2.8 It goes without saying of course that sustaining this capacity depends upon the Fund's continuing ability to attract - among both its volunteers and its staff - *good people* who bring different skills but share a commitment to improving health and related services and see the Fund as offering excellent opportunities for them to make a valued contribution.

2.9 *This combination of independence, engagement and developmental capacity means that the Fund is uniquely well-placed to partner the people and agencies with public responsibility in enhancing their capacity for positive action in an increasingly complex world.* We need however, to strive to do this with modesty and integrity, while maintaining the independence to ask unpopular questions and being prepared to expose our own fallibility by working in what Richard Himsworth once described as 'dark, dangerous and difficult' areas.

2.10 Of course, we have overstated our case. The modern identity of the King's Fund does weave together all these strands but undoubtedly some of the strands and certainly the weaving can be done better. We have been a little disappointed that in some discussion and perhaps in the 'Modern Aims' paper itself, there appears a wish to make life simpler by reducing these capacities or eliminating significant contributions. By contrast we would argue finally that what is most central to the future identity of the Cavendish Square King's Fund is the model the Fund provides of a valued, independent agency *embracing diversity* and responsibly working towards using these overlapping strengths in ways which enhance the Fund's contribution to achieving real *impact* on the 21st century agenda for better health.

3. THE FUND IN RELATION TO ITS ENVIRONMENT

3.1 Key to the expression of this identity is the recognition that the King's Fund is *independent but not separate* from its multiple environments. Our choices of focus at any time depend on our understanding of environmental challenges, explored directly and identified in the experience of both trustees and staff who are crossing the boundary between their Fund and other roles. As an agency, the Fund is one player among a host of other parties with a shared interest in health care development - government, public authorities, professional bodies,

voluntary organisations, other development agencies (e.g. in the Universities), etc. To use an ecological analogy, we need to shape our contribution in a symbiotic relationship with other parties in this common field. Most of our work involves *partnerships*: partnerships with other funders; partnerships with government or public authorities; partnerships with professional bodies; partnerships with individual users (e.g. of our educational services); occasionally even partnership with communities.

3.2 An important consequence of these partnerships is that most of our contributions and all our real impact are *co-determined*: we negotiate with others about how what we and they bring to the partnership can be used to best effect.

3.3 The significance of co-determination is inadequately reflected in the 'Modern Aims' paper. Much of the discussion therein seems to imply that the King's Fund can determine its optimum future contributions unilaterally. There are several implications of this observation but we want to develop it as it relates to *funding*. An important strength of the Fund's strategy in recent years is the way it has used investment, particularly in its institutions, to attract other income which greatly magnifies our capacity for relevant activity. From the perspectives of institutions like the College, we not only receive income *from* the Fund, we also attract 3 or 4 times as much income *to* the Fund in grants, fees for educational programmes and reimbursement for our costs in contributing to developmental initiatives.

3.4 This '*gearing*' of the subsidy through other income enables the Fund's institutions to establish and sustain the capacity for work relevant to the Fund's primary purposes; it also requires us to serve a wider agenda or constituency. To take just four very different examples:

- with government funding the library/information service is a national resource, but by providing its home the Fund secures particular benefits for people in London and nearby;
- the London Health Partnership is also working in Liverpool and Newcastle because its other funders do not have a London specific remit - however there are a lot of similarities in the challenges facing primary care in the big cities: what we learn elsewhere may well help in addressing the particularly intractable problems of the Capital;
- recent work on joint commissioning of services for older people focused initially on five sites, two in London but others in Wiltshire, Oxfordshire and County Durham: without the capacity to work nationally we would not have attracted funds from the Gatsby Charitable Foundation and now the Department of Health;
- the European Health Leadership Programme involved participants from several countries: all benefited from this diversity, without which the Programme would have been of limited benefit to its UK members.

3.5 We believe that the capacity to mount these kinds of initiative with 'partnership' funding is an essential strength of the modern King's Fund - indeed, one wonders about the reputation of an agency which could only attract funds from itself! Again, those who prefer a simple life might want to avoid the challenge of multiple funding, albeit at the loss of much of what the Fund now does. We would argue instead that the Fund should continue and where possible expand this partnership strategy, requiring however of our trustees and senior management that they:

- distinguish between funding *from* the Fund and funding *to* it;
- ensure that investment in the former category produces a good 'return' for the Fund's primary purposes, even when combined with other funding which requires wider activities;
- provide guidelines on the appropriateness of other sources of funding;
- identify the principles (e.g. relating to integrity, quality and accountability) which the Fund wishes to see reflected in all the contributions made in its name.

4. ACHIEVING VALUED DEVELOPMENT

4.1 We have argued above that the distinctive importance of the King's Fund in the modern world is its value as an independent development agency to health and related services, mobilising a variety of resources and approaches designed to enhance the capacity of individuals, organisations and wider systems to address the major challenges of our times. We think it a justified criticism however that whatever the strengths of the Fund's different institutions, the strategies by which our unique combination of assets are used to promote public benefit have been under-developed (although we note some encouraging signs that this is changing). Given the emphasis we are putting on *development*, we also concede that the Fund's different institutions have perhaps been less than explicit about the concepts and methods which characterise their approach (and how each institution is developing a critical mass of practitioners with the requisite skills to validate the claim that what the King's Fund offers is distinctive).

4.2 We hope that both further dialogue and collaboration around these themes will be a major focus of the internal work which follows the Management Committee review in July. As one contribution to this work we have ourselves prepared a longer note summarising and illustrating what the Management College means by development - and re-advertising what we are offering to a more integrated and focused King's Fund.

4.3 Overall, the work of the College is intended to help people and organisations become more effective in delivering the changes required to achieve improvements in health and related community services. Currently this intent is expressed in three major programmes of work concerned respectively with:

- developing NHS leadership
- reshaping hospital and community services; and
- strengthening commissioning and its links to primary care;

as well as significant effort around cross-linking themes, most notably ways of achieving system-wide change in London and other big cities. The complementary paper illustrates some of the difficult challenges arising in different aspects of this work, for example as managers seek to fashion new approaches to leadership which make better use of the human resources on which health care depends and organisations work to overcome fragmentation between agencies to create the new patterns of clinical practice which changing epidemiology and advances in technology demand.

4.4 What the College aspires to bring distinctively to all this work (and to joint work with colleagues elsewhere in the Fund) includes:

- an appreciation of the complexity and continuously evolving nature of these challenges, together with the unique factors which characterise any particular situation in which we work;
- a corresponding commitment to a genuinely developmental approach to change in which , rather then offering technical 'solutions', we aim to increase the capacity of individuals, organisations and sometimes wider systems to reflect on current practice and *themselves* create positive change, so that they are better able to achieve continuous improvements in what they do;
- a value base which stresses working in partnership with people and organisations striving always to demonstrate integrity and promote their autonomy;
- the capacity to offer a wide variety of developmental activities - often in combination - ranging from personal support focused on the needs of a single individual through to large scale group methods which facilitate action learning among the parties to the whole inter-agency systems which constitute local health services;
- the willingness to sustain work on challenges which are central to the future of health care (e.g. the leadership required by a modern public health system; the strategies required for reshaping urban health care) over the medium to long term in order to achieve real impact.

5. STRENGTHENING KING'S FUND CONTRIBUTIONS IN A CHANGING WORLD

5.1 To summarise, the Fund is approaching its Centenary with significant strengths on which to build, grounded in both its 100 years of service and the growth in its capacities over the past 20 years. Key strands in its current identity and sense of purpose include:

- continuity in its core mission to promote the health and well-being of Londoners, through improving health and related services;
- its long-standing reputation for combining independence and integrity with practical engagement in the health challenges of the period;
- its commitment to working in partnership with the people and agencies who have the public responsibility for improving policies, systems and services;

- its use of the Fund's own investment income and substantial gearing from the capacity of its institutions to attract funds from elsewhere to become the largest UK health sector development agency;
- its ability to bring different kinds of perspective and method to the challenges of development;
- its functions as a safe forum for reflection and dialogue, and as a vital node in wider mutual aid networks which link people with leadership roles.

5.2 Our view is that the move to Cavendish Square and the current process of review offer us all an important opportunity to use these overlapping strengths in ways which significantly *enhance* the Fund's contribution to achieving real impact on the emerging 21st century agenda for better health. This is not however either a conservative or complacent assessment. On the contrary we believe both trustees and staff face the radical challenge of seeking to do better what the Fund's institutions already have a reputation (separately) for doing well and mobilising these different capacities in ways which create a series of more integrated and more focused Fund initiatives for the future.

5.3 We doubt that the conditions and strategies for making progress in this direction can be simply prescribed: indeed we believe that the current process of review offers the opportunity for staff, trustees and representatives of the people and agencies the Fund exists to serve to discover and create together this better future over the coming months and beyond.

5.4 We hope that the Chief Executive's July submission to the Management Committee will invite their general support for this position but also commend further action on at least the following themes:

- Stronger trustee guidance (and review) on the use of its own investment income, the appropriateness of other sources of income and the principles which the Fund wishes to see reflected in all the contributions made in its name.
- A 'rolling' dialogue between staff and trustees on the most important medium-term challenges which should be priorities for the Fund's contributions, with increasing efforts to strengthen accountability for the Fund's total impact on these challenges (rather than the work of its separate institutions).
- Internal changes to improve the capacity of staff to 'organise around passions' so as to bring complementary experiences and skills to addressing these challenges.
- A sustained effort within and across each part of the Fund to clarify the concepts and methods of development which underpin our professional practices - and to ensure that the recruitment and professional development processes are in place to ensure the Fund can offer a critical mass of staff with the requisite skills.
- An expansion of initiatives which encourage staff to learn from each other and from more systematic evaluation of particularly important or large-scale programmes or work
- Further managerial leadership to establish the conditions in which the Fund and its institutions provide a model learning organisation, passionate to

contribute with integrity and effectiveness to the development of health and health care in a diverse and changing society.

5.5 We appreciate that the approach here is a little different to the 'Modern Aims' paper in both the questions we see as fundamental and our proposals for how the Fund itself can best develop its contributions for the future. However all the questions listed at the end of the 'Modern Aims paper have been at least partly addressed in the preceding commentary - and for convenience we summarise our responses in the Box (see over).

5.6 Finally we look forward to playing our full part in the processes Chief Officers agree with the Management Committee to move forward this dialogue into action.

SUMMARY OF IMPLICATIONS FOR ISSUES RAISED IN THE 'MODERN AIMS' DISCUSSION PAPER

- The Fund should seek to ensure that its investment income is used to secure its primary purposes - which we conceptualise in the modern era as being to promote the health of Londoners, particularly through improving health and related services.

- The Fund's capacity to promote these purposes is greatly enhanced by the gearing which comes from its institutions' ability to attract significant external funding and thus sustain the Fund as the leading national health sector development agency. The quid pro quo for this wider funding is the need for the Fund's institutions to serve a much wider constituency than London.

- It is possible and desirable to combine independence and integrity with a willingness to engage practically with a wide variety of external partners - both funders and otherwise. Our commitment to development requires that activities in these partnerships are co-determined.

- The Fund exists to serve. It is its distinctive strength that is has created internally the capacity to offer a range of relevant services, all related to health and health care development. These services should always aspire to be innovative and high quality - they may also focus on the same themes (e.g. leadership development; strategic change in urban health care) over many decades; some (e.g. in the library) may even provide 'routine services'.

- In Cavendish Square the Fund can build on its strengths to increase its ability to influence change - our starting recommendations for how this might be achieved are set out in Para 5.4 and include attention to current weaknesses in our separate and combined capacities to define and deliver distinctive approaches to development, to organise around passions, and to learn better from the experience and impact of our contributions.

- Whether or not at this stage we examine internal structural changes, there is a lot we could do to create the organisational conditions and processes for better focus, synergy and impact.

- Conducted creatively, there would be considerable merit in a widespread dialogue to make more explicit the values which underpin our Fund contributions, always accepting that the Fund needs to model the capacity to use its own pluralism in working with a plural society.

/David/passions

WE HAVE A DREAM
- The King's Fund College as an ideal seeking institution

Notes from the Sunningdale retreat, April 1990.

1. VALUES

Looking towards the mid `90s, we would like to live in a Britain which values individual diversity while recognising interdependence, encourages creativity and innovation, promotes social justice, protects the natural world and offers positive leadership in the international context. More specifically, we would like to see British society increasingly develop the following characteristics:

- Individuals are offered the opportunities and support to develop their unique capacities to the full, and are able therefore to contribute their talents to the enrichment of their own lives and that of others.

- The culture welcomes diversity and change and stimulates creativity and innovation.

- People have greater control over their own lives through better information, positive rights and more access to influence and power.

- Along with these rights, people recognise their responsibilities and demonstrate their care for each other.

- This capacity to care, understand and feel for the situation of others is valued socially more than other kinds of achievement.

- There is encouragement and appreciation for what is beautiful and people accept trusteeship for the natural world.

- There is greater social justice, a more tolerant multi-racial society and more support for people who are disadvantaged.

- There is continuing prosperity with greater attention to quality in environments and services we share and to socially useful production.

- Power is more equally shared through devolution, local democracy and participation.

- Britain is more internationalist, providing ideas for elsewhere, demonstrating integrity in its leadership and promoting peace.

2. RESHAPING HEALTH AND RELATED SERVICES

Consistent with these values we would like to see the development of national health policies (and healthy public policies) based on informed public debate which are holistic in orientation and aim to promote public health through inter-sectoral action. Within this framework we want to see more integrated local health and community services which are effectively managed to achieve planned outcomes, freely and fairly available, and which value users, unpaid carers and staff as whole people. More specifically, we would like to see health services and the way they are managed increasingly demonstrating the following characteristics:

- A stronger orientation to public health and prevention.

- A dominant concern in treatment and care with understanding the individual in his/her total situation, maintaining or restoring his/her autonomy, making time for personal support and offering natural (rather than technical) help with ageing, sickness and dying.

- Services free at the point of delivery and actively seeking to promote equal access (including perhaps positive discrimination in favour of people already at serious disadvantage)

- Greater integration in health and other community services, supported where appropriate by in-patient provision.

- Aiming to set and monitor high standards and attract increased public investment.

- Treating users, unpaid carers, delivery staff and managers all as whole people whose unique contributions need to be recognised, encouraged and valued (including through welcoming more women into positions of influence)

- Effectively managed to meet these requirements through the evolutionary development of better processes and forms and real investment in learning from experience.

- More accountable (eg. through elected health authorities) to an informed local public and seeking greater community group involvement.

- Increasingly oriented towards trans-national developments in health policy and provision.

3. THE COLLEGE CONTRIBUTION

We are of course part of society and the College is part of the network of influences on health services which we wish to see moving in these directions. We have the privilege and responsibility through our work of seeking to inform and assist these developments. What we do should express what we believe, and the way we do it should model the values we have identified. More specifically, we are working towards ensuring that College interventions increasingly reflect the following characteristics:

- Our work is planned and guided by explicit attention to the values identified in 1.

- Through contributing to management development and organisational change, we are concerned to address the outcomes identified in 2.

- To the best of our ability, we seek to be enabling and empowering of those we work with (not directive, manipulative or elitist) while at the same time challenging assumptions and behaviours which reduce their effectiveness in empowering others to achieve positive goals.

- We aim therefore to help people:

  * explore the relationship between action and outcomes
  * test ideas which will enhance the quality of managerial processes
  * work creatively with others in managing change and uncertainty
  * integrate ideas, feelings and behaviour

- We seek also to:

  * get involved in policy networks and debates
  * address issues of public accountability and the devolution of power
  * work on the boundaries between different groups of stakeholders including the 'community' in its various forms
  * help to lever change (eg. through contributing to the assembly of 'critical masses')
  * work with whole organisations and 'vertical slices'

- We aim to shape our portfolio towards innovative, high quality, low volume contributions with significant impact.

- While maintaining the focus in British health services, we seek also to contribute and learn from work which is:

  * cross-sectoral
  * comparative
  * cross-national

4. THE COLLEGE AS AN INSTITUTION

In order to maximise these contributions we need to develop the capacity of the College itself - for purposeful action, for using effectively and valuing all its resources, for maintaining its reputation and financial viability. More specifically, we aspire to strengthen the College as an institution by ensuring it incorporates the following characteristics:

- A continuing effort to work towards collective agreement on the directions to be pursued and the values on which these choices are based, while respecting diversity among its members.

- A conscious and continuing effort to model these values in our work with clients and our relationships with each other (including here promoting equal opportunities in a multi-racial society).

- A commitment to making health and health services our main (but not exclusive) arena.

- A concern therefore to ensure that our work is planned to reflect the aspirations in 1 and 2 (including our support for core features of the NHS, our developing philosophy of management, our commitment to quality and equity in the NHS and related services, and our interest in promoting public health and improving community health services).

- An interest in shifting the balance between management development, research and publishing activities, better relating our work to that of other parts of the Fund; and increasing collaborative work with other appropriate development agencies.

- A commitment to sharing and supporting passion in our work and supporting each other in mobilising the courage of our clients to work for positive change.

- An increasing capacity to reach collective decisions on what we do while mandating individuals and groups to act with our authority in doing it.

- Clear recognition and respect for the interdependence of different staff contributions.

- Group concern for the welfare and growth of individual staff.

- Willingness to address conflicts, accept differences and learn from creative tensions.

- A conscious investment in internal reflection and learning processes and a willingness to ensure that our ideas and methods are critically examined.

- Proper investment in the quality of educational environments, infrastructural support and the efficiency of the business.

- Proactive resource management with particular attention to use of the Fund subsidy and the level of fixed costs.

-oo000oo-

Policy and Politics vol 24 no 3

REVALUING THE NHS: empowering ourselves to shape a health care system fit for the 21st century

David Towell

Like the United Kingdom itself, the National Health Service needs renewal to meet the challenge of the next century. Critically, this requires that we reexamine the values which underpin the NHS – building on its postwar foundations but learning from subsequent disappointments and adapting to contemporary conditions. By reflecting on personal experiences we can identify values informing the everyday practice of successful health care and show their relationship to wider social assumptions which provide the context for health system design. Through sharing in dialogue about these values we can empower ourselves to shape a better future.

Tout comme le Royaume-Uni lui-même, le service de santé de la Sécurité social doit se renouveller pour faire face au défi du siècle prochain. À cette fin, il est nécessaire de s'efforcer de re-examiner les valeurs sous-jacentes au service de santé de la Sécurité sociale afin de construire sur ses fondations de l'après-guerre, en prenant en compte ses déceptions successives et en les adaptant aux conditions contemporaines. En réfléchissant sur l'expérience personnelle nous pouvons identifier les valeurs nécéssaires à une pratique quotidienne réussie du service de santé et les mettre en rapport aux suppositions sociales plus larges qui encadrent le système de santé social. Par moyen de dialogue autour de ces valeurs nous pouvons nous rendre plus forts pour façonner un meilleur avenir.

Introduction

As part of its 21st anniversary celebrations in 1994, the University of Bristol's School for Advanced Urban Studies (as it was then) convened a special seminar on the future of health care in the United Kingdom. As one of the contributors, my brief was to examine the *values* which have underpinned the development of the National Health Service (NHS) – the publicly funded and delivered health system which has proved the most popular and enduring social invention of the post-Second World War era – and the relevance of these values to its future. I was asked to approach this task from the perspective of a social historian.

Of course this is not a 'detached' social history: the evolution of the NHS and the challenges it faces today are part of the histories of all those who participated in the seminar. As citizens, as patients, as workers in the NHS and as members of the changing society in which the NHS is embedded, we are living this history. We are in a position to reflect on our own experiences in these different roles, to engage in dialogue with others about their meaning and indeed to act on these understandings in seeking to promote improvements.

In adopting this proactive stance, discussion at the seminar suggested that we need to overcome three barriers. First, the radical changes in the organisation of the NHS since 1989, with the introduction of an 'internal market' among public providers of health services and public authorities purchasing these services on behalf of local populations, have focused much attention on what have turned out to be continuously evolving questions of 'market management' in this system. These are important questions but

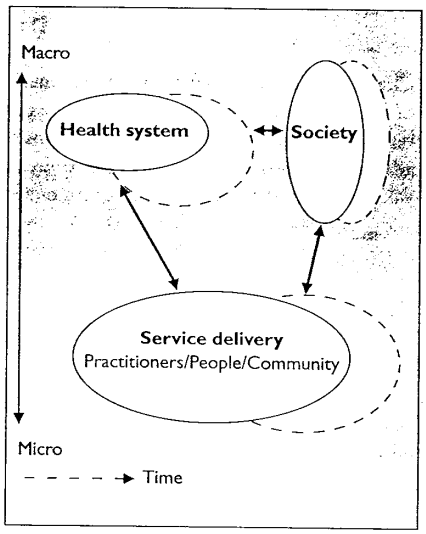
in looking forward we have to avoid being captured by an agenda which is obsessed with structures and 'business' transactions. Second, we have to counter the tendency of recent years for ideology to define reality. On the contrary, we should strive as far as possible, following Vaclav Havel's famous dictum, to "live in truth" (Havel, 1978): that is, to examine closely the actual experiences of people using, providing and shaping health care in order to inform our view of a desirable future. Third, we have to appreciate that many people, both professionals and the wider public, are deeply sceptical about the direction of recent British 'reforms'. For many involved in the system there is a sense of fragmentation, demoralisation and uncertainty which itself undermines the capacity for positive thought about the future.

At a time of rapid social, political and technological change, this future is of course unknowable. The seminar participants concluded that in facing these challenges we need to:

- Join together in examining the trends which provide the context for health care development into the next century: demographic changes and new patterns of employment, family life and cultural understanding; new expectations about positive health in a more informed, and possibly more concerned, society; new technology affecting both health care treatment and communications; and new thinking about patterns of health care provision (eg the current interest in strengthening the role of primary health care).
- Foster reintegration of the fragmented interests and elements in the current health care system in order to develop a shared sense of the issues arising from these trends.
- Establish firmer ground from which to address these issues and uncertainties with confidence by reconsidering the values which should inform the future development of the NHS.
- Seek to use these values to re-empower ourselves as active participants in shaping this future.

Keeping the first two elements of this programme in mind, my brief was to address the third and fourth elements. I suggest that this requires examination of three broad domains of action, conceptualised as Society, the Health System and Service Delivery, and their dynamic interconnections over time (see Figure 1, which I have optimistically labelled 'Towards Renewal').

Figure 1: Towards renewal



Using this framework, I want to explore a set of interrelated propositions. Starting from a detailed personal example, I try to identify important values which underpin the everyday practice of successful health care. This leads in two directions. First, it suggests that the design and development of health systems should give particular attention to what is required routinely to ensure that these values are represented in the experience of users and providers of health care. The idea that health system design should be value-driven is hardly novel, but bears restatement in contemporary circumstances – especially with this emphasis on essential features of service delivery. Second, the same example points to the importance of wider social assumptions in providing the context within which valued action at the micro-level occurs.

The relationship here is dialectical. The nature of our society is strongly reflected in the values embodied in national health care arrangements; the transactions involved in health care delivery are the main way these values are experienced; given the significance of health in

everyday life, these transactions are therefore an important part of the way our sense of society is constituted. This is unfamiliar territory in many more technical discussions of health systems, but we neglect it at our peril if we want to understand the public importance of the NHS, surely essential in a country where this particular state institution has enjoyed such unique popularity for nearly half a century.

Turning the argument round, and reflecting on the current state of British society, with its pervasive sense of both personal insecurity and political uncertainty, I suggest that there is a wider need for us as citizens to consider the values we want to shape the future. Focusing this 'revaluing' on the NHS offers one significant building block for any project of social reconstruction. If we are to grasp the opportunity and accept the responsibility for acting on our values, it is important, however, that we examine both the strengths and the disappointments of the postwar inheritance in the context of the new challenges we are facing. Drawing together each of these themes, I conclude with a succinct restatement of the values which might inform our efforts to redefine an NHS fit for the 21st century.

The NHS in action

Consistent with my brief, I shall try to explore and examine these propositions, not in an 'academic' way, but rather through the perspectives of the family whose experiences over the past 50 years I know best – the Towells. This is, of course, neither a large nor a random sample. Other families will have different experiences which in turn illuminate different facets of our shared history. What the focus on personal experience does is to ground the analysis in everyday realities which we know well and invite readers to review their experiences against mine, thus testing, modifying and filling out this analysis in ways which we can all find meaningful. These stories thus become a vehicle for a wider dialogue out of which we can shape a richer, shared vision of an NHS able to serve all our people appropriately.

There were four members of the nuclear Towell family: my parents, Frank and Ethel, my sister Pat, and me. I am particularly well placed to be narrator in this commentary on lived social history. On the day the war in Europe ended, Ethel attended both a football match and a dance: clearly impressed by the excitement, the infant David decided to emerge into the world to start the postwar generation. I was to become a major beneficiary of the welfare state, from free orange juice to the most expensive education taxpayers' money can buy. All my working life to date has been spent in agencies dedicated to improving public services. Meanwhile Pat has been the focus of even more public investment although with considerably less satisfactory outcomes, as I shall explain. I want to begin, however, with our parents, Frank and Ethel.

To start at the end, Frank died some three years ago. This was a great loss to us, but he had a very full life spanning all the major events of this century and at the age of 87, death was not a great surprise. As a health minister (Enoch Powell) once commented, the most certain health statistic is that mortality is 100%. Precisely because dying is so common (even if only once for each of us) it seems a reasonable expectation that the NHS should aim to ensure that we all have the opportunity to die in the manner of our living. In my Dad's experience, I think this was largely achieved and I want to use his example to explore what may commonly be involved in a 'good' death.

In retrospect, we know that the last phase of Frank's life began with a serious bout of 'flu, shortly after Christmas 1992. The trajectory of this illness remained uncertain until very near the end – was he getting a bit better? was he still declining? – but in fact he never did recover, spending most of the last six weeks more-or-less in bed, until a major stroke left him unconscious and he died three nights later.

All but this very last episode took place at Frank and Ethel's home, where we found ourselves at the centre of what was both a unique drama (for the Towells) and everyday practice for a variety of health workers. This drama had a substantial number of players. Central, of course, was Frank, who remained significantly involved until the last act, not infrequently in ways which reflected his lifelong strength and determination but which contradicted our care plan, eg by trying to get up when we felt staying in bed would be wiser and declining nourishment when we were working hard to increase his consumption.

Equally central was Ethel, who at the age of 82 found herself the only 24-hour care giver for

this last six weeks, and the cog around which all other support revolved. After sixty years of married life, this care was given with love but not without understandable anxiety and stress, which was reflected in considerable loss of weight in someone who was already quite small. Ethel would also want the other constant family member, Heidi the dog, mentioned in dispatches – who sat guard over Frank's chair throughout his illness and indeed has occupied it ever since.

In truth, my own role was considerably more modest (compared with Ethel, not Heidi). I used my knowledge of the health system and advocacy skills to alert the health centre staff to our view that this was not just another case of winter 'flu. I did a small share of night and weekend duty, also using my chequebook to extend the support Ethel received at other times. I 'chaired' the daily and sometimes more frequent 'case conferences' (admittedly often by telephone from 100 miles away), always involving Ethel and Frank (at least in spirit) and sometimes other players as well as we sought to understand what was happening and to decide what should be done next, often in the face of conflicting pressures, including a continuing debate about whether 'hospital' or 'home' was better.

We were not the only 'unpaid' care givers. Frank was well known in the community and many people asked after him. More specifically, three sets of neighbours gave extensive informal support, both to Frank and Ethel, often at times and in ways which professionals found more difficult. Mary lived close by, had been a nurse before the war, and was a great help in feeding and lifting Frank and giving general support to Ethel. Laraine was my age, had also been a nurse, and was always willing to use her car in a good cause, including following the ambulance on the last journey. Bert and Wyn were happy to drop in frequently, sit with Frank, and help out with shopping.

On the professional side, there were two main kinds of worker, assessors/resource mobilisers and paid care givers, though their activities overlapped. Among the former, the most central was Frank's general practitioner (or rather him and his partners at the health centre, since they shared out-of-hours cover). The GP was the most authoritative contributor in terms of providing ongoing diagnosis of Frank's condition, advising the rest of us about what help Frank required, and organising other paid support from health workers and, via the social services team manager, of home care workers.

The paid domiciliary support was provided by the district nursing service (three different nurses over the six weeks), home care team (four different care assistants) and a private nursing agency (four or five care workers, mainly moonlighting from jobs in a nearby hospital) which was particularly helpful outside office hours, when Ethel was most anxious and the public sector workers least available.

It is not necessary, and indeed there is not space, to provide the full script for this six-week drama with its 20 or more regular actors. Suffice it to say that Ethel and I believed then and now that it was right that Frank lived out his (conscious) life at home and that, with the support of neighbours and paid workers, this was a good conclusion to what had undoubtedly been a good life.

In describing this story as a drama, however, I am implying that this was not achieved without considerable difficulties. I have mentioned already the stress on Mum. This stress, and the provision of care to Frank, were made more difficult by the problems of coordinating different professional services (eg so that neither the district nurse nor the home care worker found themselves trying to lift Frank with only Ethel's assistance) and the weaknesses in out-of-hours support from the public sector, so that one wonders what happens to families who are not in a position to buy private sector supplements. With hindsight, it may also have been a mistake that right at the end Frank was admitted to hospital. After the major stroke, the district nurse concluded that Frank was not just sleeping peacefully but was actually unconscious and called an ambulance, effectively pre-empting any further discussion at the daily 'case conference'.

Overall, however, this is an encouraging story about what patients, families, friends and the caring services can do in achieving that most basic of aspirations: to die with love and dignity in one's own home at the end of a fulfilling life. The significant lesson I want to draw from this story is that achieving this common and apparently simple objective requires, for many people:

- an intricate web of paid and unpaid contributions skilfully coordinated through mutual understanding;
- the availability of excellent consultancy skills at the patient's side, able to provide guidance on the trajectory of illness and the kind of help most required;
- even more important than technical skills, the expression of supportive and caring attitudes towards fellow humans (best reflected in this case by the willingness of both the neighbours and least-paid workers to come back or telephone in their own time to offer Ethel support);
- crucially, the central role of family members in making any sustained support of this kind possible.

Moreover, although dying is in an important sense a special case, this story can reasonably be seen as typical of the dominant forms of health and social care required by both the changing epidemiology (the increasing significance of chronic illness and disability) and changing demography (notably the rapidly increasing numbers of us who are making it into what was previously regarded as very old age) – that is, labour intensive health provision directed towards continuing care and health maintenance. This is not to underestimate the contributions of high technology interventions focused on cure or repair, currently (but perhaps decreasingly) associated with hospitals, and what can be expected from their further development in the coming years. In contrast to much popular imagery, it is rather to see these services as supporting the everyday business of community health care.

What are the values which underpin the kind of support which was crucial to Frank in dying as he lived and to these wider examples of health and social care? Looking first at the 'micro' level of service delivery, the following seem most important:

- solidarity among community members, most intensively felt within the family, reflected in a shared responsibility for assisting each other in times of need;
- further expression of this solidarity through the availability of professional help, delivered as a public service, with the expectation that this will be offered fairly and appropriately to people's needs and be readily accessible;
- respect for the autonomy of patients and unpaid care givers (without denying conflicts of interest) so that as far as possible the professional/client relationship is one of partnership;
- a holistic approach to providing support which seeks to understand illness or disability in the wider context of people's lives and judge effectiveness according to the outcomes achieved in sustaining or enriching life according to informed patient preferences;
- complementary trust in the professional integrity of paid workers, ie that they will do their best in the interests of patients and their closest unpaid carers and be accountable for their contribution;
- reinforcement of the personal contributions which the preceding values require by working arrangements which respect the essential humanity of both the providers and users of health care.

The main conclusion I want to draw from this extended illustration is that the design and development of health services, and the health systems in which they are embedded, need precisely to be based on this kind of analysis of the transactions involved in the everyday business of caring and the values needed to underpin this most sensitive and potentially fragile enterprise.

The NHS and society

Of course, these 'micro' transactions between patients, unpaid carers and professional workers take place in a wider context. Expressions of solidarity and respect for autonomy reflect popular assumptions about the responsibilities to each other we accept as members of the wider society. This wider solidarity is also reflected in the availability of public services, largely free at the point of delivery and provided fairly according to need, following the collective decision to pool the risks associated with ill health. The adoption of the public service model as the vehicle for organising professional support to meet these needs brings with it further expectations about the integrity of providers and their attitudes to the people being served. And the accountability of these services at the macro-level is reflected in

the establishment of democratic processes (ultimately through Parliament) for governing the national health system.

We can see therefore a necessary resonance between the values embodied in the relationship between the health system and society at the macro level and the values which inform the more personal relationships involved in service delivery. Indeed, and more radically, it seems reasonable to claim that the values embodied in our national health care arrangements are both a strong reflection and essential building block of society. A strong reflection, because surely only a society where there is wide commitment to mutual responsibility, fairness and democracy could both create and sustain a national health system with these characteristics; and reciprocally, an essential building block because of the universal experience and the universal importance people invest in the support they receive at times of illness and the significance of these experiences therefore in representing the everyday meaning of a caring society to us all.

Again, Frank and Ethel's experiences provide testimony to these arguments. If my account of Frank's death is largely a positive one, they may reasonably claim this as a richly deserved entitlement. Through their experience of the two World Wars and the long period of economic depression in between, and through sharing with the mass of ordinary people in the titanic struggle to defeat Fascism, they became part of the social movement which produced the welfare state. With fellow citizens of their generation they believed themselves to have achieved this peaceful revolution in British society.

In my role as social historian, it is striking now to recall the self-confidence of ordinary people which underpinned the creation of the NHS. In the midst of a devastating war, the Beveridge Report (HMSO, 1942), which shaped postwar welfare legislation, sold 650,000 copies. Nearly everyone knew something about its main proposals. Beveridge envisaged a comprehensive National Health Service in which "for every citizen there is available whatever medical treatment [he] requires in whatever form [he] requires it" (Beveridge Report, 1942: 158). Over 40 years later, the distinguished policy analyst Rudolph Klein was able to write that the NHS has been "an outstanding success story in that it delivers a comprehensive and reasonably equitable service at a remarkably low cost" (Klein, 1992: 23). For their part, Frank and Ethel had no doubts about the importance of the NHS as a visible expression of a new social contract between people and a vital element in the fairer society which the defeat of Fascism had made both possible and essential.

Nearly half a century later I was myself reminded of the social significance of this achievement by working in the (former) Czechoslovakia in the period after the 'velvet revolution'. The defining theme of the political movement Civic Forum, which brought down the former regime, was the need to recreate civil society after the end of totalitarianism. Vaclav Havel, the dissident playwright spokesman for this movement and the first President of the new Czecho-Slovak Federal Republic, suggests the wider importance of this theme: "...the only way to save our world lies in the democracy that reminds itself of its ancient Greek roots: a democracy based on an integrated human personality personally answering for the fate of the community..." (Havel, 1993). Significantly, Havel also identifies health care as a critical element in the programme of social reconstruction:

> Since time immemorial, a part of human culture has been man's care for himself, for the body in which the spirit resides – that is, for his own health. The culture of healing may be a less visible aspect of life, yet it is perhaps the most important indicator of the humanity of any society. (Havel, 1992: 118)

More concretely, we see from our own experience that the services for which the NHS are responsible:

- address the area of our lives which people value most highly – health – and the most common causes of anxiety – illness and pain;
- touch us all literally 'from cradle to grave';
- impact on us more intimately than any other kind of professional service.

The NHS is also one of our most 'visible' institutions. Its main facilities are well-known landmarks. It employs one in 27 of the working population. Being a nurse or a doctor is a valued

social role. For these reasons, and because of its enduring historical legacy, the NHS continues to retain enormous popular significance as a central statement about the kind of people and the kind of society we wish to be.

Distortions and disappointments

In highlighting the significance of this heritage and the continuing importance of the values which underpin the NHS, however, it is not my intention to present an idealised version of the NHS in practice. We know that Frank was relatively fortunate: many of our fellow citizens do not receive the care they need to die with dignity. Indeed, for many people, particularly the most vulnerable, the NHS and other care services are something of a lottery in which positive experiences seem more a matter of luck than judgement. Even Frank's story illustrated the need to plug the gaps in public services by purchasing care from the private sector – an option not easily available to many families. Furthermore, buying support in old age is becoming increasingly common as the NHS withdraws from its commitment to continuing care.

More fundamentally, the NHS was weakened from the outset by an interrelated set of factors which has meant that the reality of health care provision falls considerably short of public aspirations. First, the original conception of the function of health services was perhaps too much orientated towards a 'repair model' (eg providing glasses and false teeth) focused on what (after the backlog had been cleared) was mistakenly seen as a self-limiting volume of illness, and suggesting therefore that a quite containable proportion of GNP for 'comprehensive' provision would be possible. Second, the values defining the NHS were formulated in the conditions of the 1940s and 1950s when, for example, there was a stronger sense of social solidarity and relatively little emphasis on individual choice. Third, the arrangements adopted for this national public service were similarly influenced by the economic and political preoccupations of the 1940s (eg the confidence in state planning) and the need to compromise, most evidently in the remarkable deal struck between government and the medical profession. Finally, like any large institution, the original good intentions which motivated the creation of the NHS were moderated both by the impact of competing attitudes (eg paternalism) in the wider society and by distortions arising from bureaucratic politics and the need for front-line workers to protect themselves from the pressures involved in delivering such anxiety-provoking services.

This is not the place for a comprehensive assessment of the impact of these influences. Focusing on the values already identified, however, it is possible to highlight those features of NHS performance which will need to be addressed in any programme of health sector renewal.

(i) In relation to social solidarity, the NHS has provided an excellent system of insurance against the impact of illness. The Beveridge reforms as a whole also provided a bold framework for providing the population with the conditions necessary for good health. Even so, the welfare state has given insufficient attention to linking personal and collective responsibility for positive health, not so much through the health care system (although there is undoubtedly scope for a stronger NHS contribution) but rather through tackling the other 'giants' Beveridge identified and, as we now see more clearly, pursuing 'economic' policies which promote quality of life, rather than consumption, and protection of the natural world (the only home we have) for future generations.

(ii) The NHS has (by international standards) proved relatively successful in promoting equity of access to health services and the allocation of national health resources according to need. This relative strength covers a multitude of weaknesses, however, captured most strikingly in the 'inverse care law' (the greater the local need, the less the availability of appropriate services) and including inequalities related to gender, ethnicity and types of illness, all of which pose the challenge of achieving equity in conditions of social diversity.

(iii) Control of the NHS is ultimately rested in democratic institutions, notably the Secretary of State's accountability to Parliament for the full range of its activities, and this democratic form has been further expressed in a variety of processes (lay membership of health authorities, the creation of community health councils to represent public views, the requirements for wide consultation on local plans, etc). Nevertheless,

from the beginning this democratic control was heavily centralised and local management (once community health services were transferred from the local authorities) has relied exclusively on 'quangos'(ie non-elected public bodies). The case for a national system remains strong but there is also considerable scope for increasing responsiveness and accountability to both patients and citizens at the local level.

(iv) Turning to the delivery of services, the concept of quality is necessarily multi-faceted. There is much to praise in the achievements of the NHS in providing a wide range of decent services locally, largely free at the point of delivery, with universal access, and until recently at least, this provision has been popular with the public. However, the story is considerably more complex than this. It is one of the great successes of the NHS that it does so much, so cheaply (by international standards), ie at around 6-7% of GDP. Arguably, the resources saved from health care are available for investment in positive health, for example through education, housing, and income support programmes. At the same time, this relatively cheap cost is reflected in limitations to the comprehensiveness of the service (eg the lack of night time domiciliary care), barriers to access (eg waiting times for hospital treatment), lack of capital investment (eg the nineteenth-century workhouses which are still being used and which will survive into the next century) and the poor standards of care which are still offered through all those 'Cinderella' services (ie, services for people needing long-term care) which were rediscovered in the 1960s and have been 'priorities' ever since.

(v) Just as important to quality are the conceptions of health and health care which have informed the definition of health services. As has been noted already, the NHS has been weakened by too great an emphasis on a narrow medical approach which has prioritised acute rather than chronic illness and treatment rather than care. With changing patterns of population health, it is increasingly necessary to reemphasise the primary function of health services to enable people to maintain their own lifestyles in the face of physical and psychological threats to their well-being. This requires a greater emphasis on health maintenance and continuing support, mainly delivered through stronger primary care, backed by more specialist (and sometimes more centralised) interventions when necessary.

(vi) More subtly, there is also a need to rethink the pattern of relationships within which health care is embedded. Commitment to public service ethics is important, but with greater recognition of the part professional services play in the informal networks of support to individuals which actually provide the mainstay of necessary care and which at best we call 'community'. Paternalistic approaches and professional attitudes in which the focus on illness means the person is lost from sight need to be replaced by respect for the autonomy of the person and the creation of professional/patient partnerships in which professional expertise is combined with self-help to optimise health. This is particularly important in supporting people who, through chronic ill health or serious disability, are potentially most vulnerable to loss of control over their daily lives and exclusion from the social networks others take for granted. In turn, there is a continuing need to stress the importance of professional integrity in this partnership, but with greater attention both to the effectiveneness of the intervention and to a holistic view of the outcomes being sought (ie, responding to the illness in the context of the total life of the person and their social situation).

(vii) Finally, all of this is not possible unless the people at the front line of service delivery and those who support them feel their contributions are properly recognised in the wider organisations of which they are a part.

Opportunities for renewal

In building on the strengths of the NHS in its first 50 years, there is therefore a significant agenda for improvement. In addressing the needs of the next century, however, the challenge – and the opportunity – is more radical.

Returning to the macro level of analysis, there can be little doubt that as a society we are experiencing a period of disarray. There are many aspects to this, but uncertainties in the political sphere are particularly revealing. It is clear that the postwar 'forward march of labour' has long been halted, essentially because the social conditions which gave cohesion to working class political movements have dissolved as a result of changes in employment, housing and

communications. It is also becoming more evident that the conservative political tradition as we have known it is increasingly fractured by the conflicting pressures of conservation – preserving the traditions which give continuity and authority in social life – and the market philosophies of the 'new right', which have accelerated the erosion of these traditions. At the individual level, these trends are reflected in the increasing sense of insecurity and anxiety which pervades many people's lives. At the societal level, there is a feeling that society has lost its way, a pessimism about the future and an impotence about our efforts to change this.

We cannot go back to an earlier age, even were this desirable. The social conditions of the late 20th century – the internationalisation of economic activity, the changing world of work with its impact on the roles of men and women and significance for 'the family', growing cultural diversity and greater individualism – demand that we find new ways of expressing important values. Of course, continuing national decline is possible. However, the recognition that we have lost our way provides the opportunity for social renewal, for confronting these long term trends with fresh efforts to rebuild a civic culture based on interdependence and mutual obligation, which at the same time recognises the pluralistic society we have become.

It is a thesis of this paper that the NHS as a social institution has offered some protection against the forces which have undermined social cohesion and now provides one vehicle for reconstruction. This requires, however, that we reframe the values which underpin the NHS in ways which build on the postwar foundations but which also learn from unfulfilled expectations and adapt to contemporary social conditions, including the changing nature of health needs themselves. Recalling the framework presented in Figure 1 and distilling the themes discussed earlier, the essential elements in this restatement of values are a commitment to mutual responsibility, equity and democracy at the macro level, and quality at the micro level – understood as providing opportunities and services which enable people to maintain their own lifestyles. As we have seen, quality in this sense is necessarily multi-dimensional but much of the analysis here points similarly to three fundamental values:

- respect for the autonomy of individual patients, demonstrated in partnership between professionals and their clients in the joint production of health which reflects users' own views about positive outcomes;
- commitment to integrity in public services, through developing an ethical and accountable basis for practice which always strives to express the essential humanity of caring in its deepest sense;
- recognition that both service providers and citizens need to appreciate and promote the community solidarity which is essential in ensuring informal support for most people at times of illness and distress, and indeed upon which the success of these services typically depends.

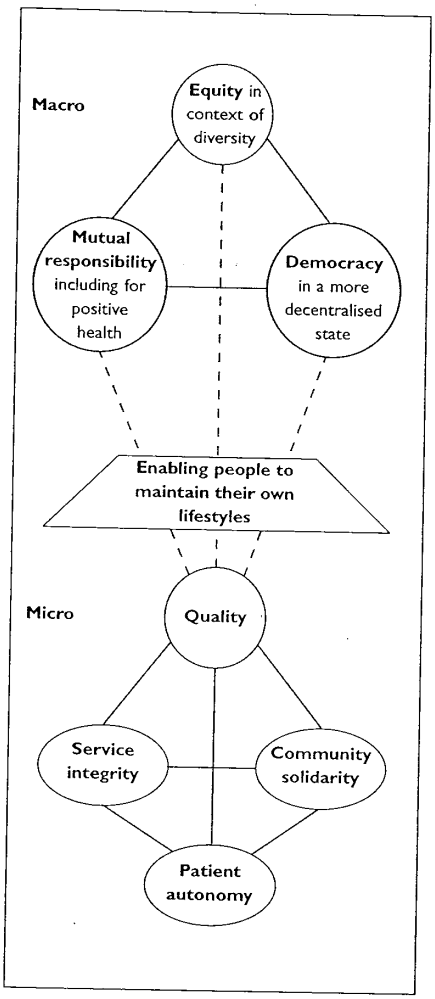
These values and their interrelationships are summarised in Figure 2.

Epilogue

This broad restatement of NHS values for the 21st century is necessarily both selective and programmatic. Readers reflecting on their experiences might well emphasise some other themes or organise the analysis a little differently. Moreover, the implications of these values for any particular health challenge need to be worked through in greater detail, taking account, for example, of the situation of users, the current technologies of intervention, organisational requirements and costs – and carefully exploring trade-offs between achievements on different dimensions. The purpose of this reflection and more detailed analysis is, however, to empower our own contributions to informed change.

Returning to concrete examples and my personal experience, I would like to reintroduce my sister, Pat. Pat was born in 1936, a healthy child. Shortly afterwards, however, she contracted a severe case of whooping cough which caused major brain damage, leaving her with a severe learning disability. I have a nice picture of Pat as a child, standing on the beach at Great Yarmouth, but this image disguised her need for a great deal of help in every aspect of daily life and the difficulty there could be, for example, in feeding and dressing her. Ethel, of course, made the major contribution to this support and during the war years there was not much professional help available.

Figure 2: NHS values for the 21st century



My arrival was the occasion for Pat's admission to long-term care, which at the time was seen as a 'permanent solution'. She began a lengthy career in what were soon to become (following the take-over of local authority responsibilities for the institutions) NHS long-stay hospitals. Consistent with the NHS commitment to serve all according to need, Pat has received 24-hour care ever since. In many other respects, however, her experience, like that of many thousands of people requiring lifetime support, has fallen far short of meeting quite basic expectations. It is only now, at the age of 59, that Pat is again preparing to move with a few friends to an ordinary home, where paid staff, friends and neighbours will be able to help her regain some aspects of the fuller life most of us take for granted – to have one's own bedroom, to eat food cooked at home, to go out shopping, to meet friends for ordinary leisure activities, to see children playing.

Interpreting and implementing the values identified in Figure 2 for Pat and many other people with serious disabilities is, of course, a significant challenge. At the macro level, it requires not only that we share the responsibility for providing support but also that we work towards creating a society which welcomes all its members by opening up opportunities and reducing barriers to participation. At the micro level, even more than in the story of Frank, it requires subtle and skilled efforts to link informal help and professional contributions in ways which respect people's autonomy and maximise the quality of their everyday life. Again, we see in this example the interweaving at both macro and micro levels of the health system and the kind of society/community we wish to become. This example also shows us (as I have described in detail elsewhere: Towell and Beardshaw, 1991) that substantial progress is possible through people who share these values coming together to develop and act on a shared vision of a better future.

Similarly, on the wider agenda for developing an NHS fit for the 21st century, we are all players in the drama of social reconstruction (or its failure); we are making history as well as living it. It is the argument of this paper that we have now an important opportunity to act on this responsibility. If the challenge seems a big one, we can take heart from the success of Frank, Ethel and their fellow citizens in the 1940s and renew our commitment to building on their legacy.

References

Havel, V. (1987) 'The power of the powerless' (English translation: first circulated in Czech in 1978), *Living in truth*, London: Faber and Faber.

Havel, V. (1992) *Summer meditations on politics, morality and civility in a time of transition,* London: Faber and Faber.

Havel, V. (1993) Speech on receipt of the Onassis Prize for Man and Mankind, Athens, May.

Klein, R. (1992) 'Strengths and frailties of a 1942 citizen's charter', *The Guardian*, 4 March.

Social Insurance and Allied Services (Beveridge Report) (1942) Cmnd 6404, London: HMSO.

Towell, D. and Beardshaw, V. (1991) *Enabling community integration: the role of public authorities in promoting an ordinary life for people with learning disabilities in the 1990s,* London: King's Fund College.

David Towell
Fellow in Health Policy and Development
King's Fund College
London

CLARIFYING THE NATURE OF (OUR) PROFESSIONAL PRACTICE

1. Goals

Overall, the purpose of our interventions is to increase the capacity of individuals, organisations and wider systems to achieve positive gains for people and communities in a changing world (within the domain of health and related welfare).

This purpose is further defined by:

* Important dimensions of positive gains include:-
  - autonomy, health and well being for individuals;
  - more integrated communities in which currently disadvantaged people are full participants;
  - a more just and democratic society;
  - a world whose future is protected.
* (In my case) a focus on continuity and change in organisations and inter-organisational systems, while recognising that individual, group and network development will typically be required to address system-wide challenges.
* A preference for strategic challenges (ie: defined by the significance of the desired change, the size of the system, the period over which change is sought ...)
* A preference for medium-term interventions (seeing the film rather than taking a snap-shot) and therefore planning short-term interventions as part of a longer-term process whenever possible.
* a conceptualisation of increased 'capacity' as (probably) involving:
  - increased understanding of relevant challenges;
  - greater clarity and energy of purpose;
  - development of appropriate strategies;
  - more effective leadership;
  - better forms of organisation;
  - Greater valuing by organisations of their members as well as their clients.
  - establishing processes for further learning.

2. How - Approaches and Methods

We pursue these goals through *collaborative action learning* (as defined by Gareth Morgan) ie: we work in partnership with representatives of the 'client system' both to enhance their capacity for informed action and to develop insights (and perhaps 'working models') of potentially wider relevance.

In this collaborative relationship, we:

* Make explicit that we are bringing our own values and perspectives to the partnership.
* Invite client representatives to see themselves as part of the system to be changed.

* Seek to ensure that there is a mandate from relevant stakeholders (ie: who may go beyond the initial client 'representatives') for any programme of change.

* Keep in mind the wider interests (eg: of service users and the public) when working within agency systems.

We also strive to:

* demonstrate integrity eg: in being honest, protecting confidences and appreciating our own fallibility;

* promote autonomy ie: recognising that while some temporary dependence is often an element in helping relationships, our over-riding aim is to ensure clients accept responsibility for action on the challenges they face and grow in capacity to address these and subsequent challenges.

Our work involves helping 'participants':

* Find new ways of defining their situation, challenges and options for action.

* See their own roles and agencies in their wider social and political context.

* Appreciate less conscious processes which may be distorting intentions or aggravating conflict.

* Develop empowering visions of what would be better.

* Engage both the spirit and the intellect in taking action on these visions.

* Achieve renewal in the sense of finding the confidence to act more proactively on participants own values in changing circumstances.

* Accept the uncertainties, anxieties and loss involved in any complex change process.

To do this we select from, and combine, a variety of methods which include:

* Ethnographically-orientated listening and sampling from organisational life to develop our 'reading' of the situation.

* Search conferences and other carefully designed interactive events to help people find common goals and new ways of working.

* Facilitation to ongoing and temporary task groups as they work to explore innovation.

* Graphic recording as a vehicle for group problem-solving.

* Networking to improve connections in fragmented systems.

* Learning sets and organisational role consultancy to help people reflect on their own experience within a 'protected' forum.

* Offering the professional-client relationship as a temporary container for the anxieties generated during change.

All of which rely heavily on the purposeful use of ourselves as the key resource to the collaborative process.

3. Understanding the Organisational and Wider 'World' in which we Intervene

We draw on a variety of *conceptual frameworks* in helping participants 'reframe' their situation and find positive directions for action:

* 'Reality' is socially constructed in everyday interactions among stakeholders with different perspectives : it is possible to recognise these processes and negotiate (ie: through dialogue) new realities.

* Relationships between individuals and groups are also shaped by psychodynamic processes, particularly the need to maintain identity and defend oneself from anxiety in the face of uncertainty : some appreciation of these processes is helpful in confronting the challenge of change.

* 'Organisation' in its broadest sense requires choices which are illuminated by exploring the connections between tasks, technology, social relations and environment, understood as an 'open system'.

* Rapid rates of environmental change require organisations and networks to become 'learning systems' in which a wide range of contributions are mobilised to achieve continuous adaptation.

* In 'complex messes' this adaptability requires forms of interactive planning which are vision-directed and open-ended.

* Leadership for systems change requires weaving together different 'strands' of strategy (environmental, substantive, organisational, managerial, cultural).

* 'Stakeholders' in these organisational processes typically have different interests, perspectives and levers of influence : these differences need to be addressed in achieving change.

* At the same time, both within organisations and in wider systems (up to the global level) there is an increasing need to recognise and nurture inter-dependence.

ANNEX : A BRIEF INTELLECTUAL BIOGRAPHY AND BIBLIOGRAPHY

As practitioners working with individuals, groups and complex social systems we necessarily bring the 'whole person' to our educational and consultancy roles. What we do and how we do it is shaped by our values and personalities, a lifetime of experience (both conscious and unconscious), our 'recipe knowledge' (ie: familiarity with particular kinds of systems, their histories, cultures and rules) and our conceptual frameworks which offer ways of understanding the world and our interventions in it.

Even the latter element of practice is difficult to make explicit because in any particular piece of work, experienced practitioners select, synthesise and hopefully innovate from a wide repertoire.

Reflecting on my own practice (and how I developed it) however, I think the following have been the most influential mentors, institutions and sets of ideas (with the most relevant references). In each case, ways of understanding the world are associated with particular forms of *intervention method*.

(i) Reality is socially constructed

My post natural science education at Cambridge was initially in sociology/social psychology. I was particularly fortunate to work on my Ph.D with Anselm Strauss. I learnt the significance of WI Thomas's famous dictum 'What (men) believe is real, is real in its consequences' and to search therefore for the definitions of situations, the ways these are established in everyday interaction and their potential malleability to change.

* Berger, P and Luckmann, T 'The Social Construction of Reality'

* Strauss, A et al 'The Hospital and Its Negotiated Order'

* Goffman, E 'Asylums'

* Silverman, D 'The Theory of Organisations'

Ways for exploring these social realities focus on *quasi-ethnographic methods*, especially *'participant observation'* and use inductive forms of analysis to generate *'grounded theory'*.

* Becker, H 'Sociological Work'

* Strauss, A 'Qualitative Analysis for Social Scientists'

The liberating potential of this recognition of our capacity to define situations differently is an important element in education and consultancy which is *empowering*.

* Wright Mills, C 'The Sociological Imagination'

* Friere, P 'The Pedagogy of the Oppressed'

* Morgan, G 'Imaginization'

(ii) There is choice in organisational design

My next good fortune and main introduction to organisation theory was five years at the Tavistock Institute, working with Eric Miller, Isabel Menzies, Harold Bridger, John Friend and others and undertaking my 'action research' apprenticeship. Key elements in the Tavistock inheritance include the idea of organisations (using a biological analogy) as open task-orientated socio-technical systems, the implications of this view for organisational choice, the examination of different kinds of organisational environment (including the early discovery of rapid change/turbulence) and exploration of inter-organisational relationships:

* Miller, E 'From dependence to autonomy'

* Trist, E et al 'Organisational choice'

* Emery, F and Trist, E 'The Causal Texture of Organisational Environments'

* Friend, J et al 'Public Planning : The Inter-Corporate Dimension'

Methodologically most Tavistock work was conducted in a *professional consultant-client relationship* through *action research* ie: involving collaboration between consultant and client in both addressing organisational challenges (particularly developing new organisational models) and drawing wider insights. Much of this Tavistock work was relatively sophisticated in its research contribution but has similarities with *organisation development* interventions and *process consultancy*, particularly the focus on individual, group and organisational change and the commitment to increasing the capacity of people to address their own challenges.

* Clark, PA 'Action Research and Organisational Change'

* Beckhard, R and Pritchard, W 'Changing The Essence'

* Schein, E 'Process Consultancy'

(iii) Unconscious dynamics also shape organisational life

The Tavistock contribution included the recognition that systems incorporate their members as whole people and that organisational life can be illuminated through a psychodynamic perspective which recognises unconscious group processes.

* Menzies I 'Containing anxiety in institutions'

* Miller E 'From dependence to autonomy'

* Marris P 'Loss and Change'

* Bion W 'Experiences in Groups'

Appreciating these dynamics and finding constructive ways of *working with anxiety* during processes of change becomes an important dimension of effective consultancy.

(iv) In an uncertain world, organisational learning is essential for adaptability

The theme of turbulence, adaptability and learning networks is strongly reflected in the Tavistock contributions (Trist, Friend) but best expressed originally by Donald Schon (and later Senge) who show how coping with the uncertainty of rapid environmental change requires organisations to become learning systems, replacing central control by peripheral innovation and becoming capable of bringing about their own transformation.

* Schon D 'Beyond the stable state'

* Senge P 'The Fifth Discipline'

There is an important role for facilitators therefore in working across organisational boundaries and *stimulating networks*.

(v) These conditions also require new approaches to interactive planning and problem-solving

Shaping a different future requires interactive processes which facilitate collaboration among interest groups, find currencies for identifying shared values and new directions, and promote continuous learning. Again, Trist's contribution is important here but some of us have learnt most from the example of John O'Brien (and nearer home, Nan Carle and Lyn Rucker) particularly their work with King's Fund networks in developing community services.

These ideas have led to a range of methodological innovations like the *future search conferences*, *person-centred planning*, *graphic facilitation* and the *use of metaphor in action learning*.

* Trist E 'Action research and adaptive planning'

* O'Brien J and Lyle C 'Framework for Accomplishment'

* O'Brien J 'Embracing Ignorance, Error and Fallibility : Competences for leadership of effective services'

* Mount B 'Making Futures Happen'

* Sibbert D 'Graphic guide to facilitation'

* Morgan G 'Imaginization'

(vi) In turn, large systems require new approaches to strategic management

My own understanding of this challenge has been particularly influenced by Tom Evans, Gordon Best and College colleagues. Maintaining direction in a changing environment and learning from the periphery requires top management to carefully weave together the different strands of strategy ie: attending in Pettigrew's terms to the context, content and processes of change over time and the maintenance of legitimacy. All this takes on a particular focus in relation to public sector trends towards authorities as essentially enabling agencies.

* Evans T 'Strategic response to environmental turbulence'

* Pettigrew A et al 'Shaping Strategic Change'

* Brook R 'Managing the enabling authority'

Our own efforts to develop these ideas in relation to the implementation of general management made particular use of *learning sets*.

* Schon D 'Educating the Reflective Practitioner'

* Casey D 'The role of the set adviser'

(vii) Power is an important feature of both the internal and external context

Much of this managerialist literature is helpfully complemented by work in the political science tradition, particularly in the public sector that concerned with policy implementation and accountability. My familiarity with this literature gained most from a decade of part-time association with the School for Advanced Urban Studies. This work draws attention to the range of interests (stakeholders) involved in change processes, their different sorts of influence (including hidden forms of power), and the implications for conflict (and conflict mediation).

(There are also, of course, complementary but more specialist literatures on industrial relations, as well as on race and gender issues).

* Ham C and Hill M 'The Policy Process in the Modern Capitalist State'

* Hoggett P and Hambleton R 'Decentralisation and Democracy'

* Barrett S and Fudge C 'Policy and Action'

* Glennerster H et al 'Planning for Priority Groups'

* Lukes S 'Power : a radical view'

* Doyal L 'The Political Economy of Health'

An interesting methodological implication of this work is the need to recognise different interests in evaluation ie: undertake *pluralist evaluation*.

* Smith G and Cantley C 'Assessing Health Care'

(viii) And we live in a world where our futures depend on appreciating and acting on a wider conception of inter-dependence

I was reintroduced to this theme by the powerful experience of working in Eastern Europe (where the commitment to establishing civic society was central to the Czechoslovak velvet revolution) but its wider significance is seen in growing recognition of our stewardship for the natural world. In health policy there are implications for public health, community integration, inter-agency relationships, etc.

* Havel V 'Summer Meditations'

* Brundtland G H et al 'Our Common Future'

* Wheatley M 'Leadership and the new Science'

* Ashton J and Seymour H 'The New Public Health'

* McKnight J L 'Regenerating community'

This requires methods which encourage sectional interests to see the 'whole' and its likely futures as a basis for negotiating 'superordinate goals'.

David Towell
Rung's Fund
~ 1994

1292 Master 5/11/97 11:26 am Page 133

Transforming London's health system

Autonomy and self-organisation in the swamp

David Towell
Fellow in Health Policy Development,
King's Fund Management College

Robert Maxwell is a man of many parts, as the breadth of contributions to this book implies. Robert joined the King's Fund, where I was already among the senior staff, in 1980. From my experience of working with him over the last 17 years, there are three main strands of his persona to which I want to draw attention – and which provide the inspiration for the essay which follows.

Reprinted from:
The Quest for Excellence: What is good health care?
Essays in honour of Robert J Maxwell
London, King's Fund, 1997

1292 Master 5/11/97 11:26 am Page 134

First there is London: more precisely the continuing struggle to improve the health and health care of London people and therefore the quality of the London health system. London is the largest and most diverse city in Europe. Health care is the most organisationally complex, politically sensitive and personally significant of its many public services. The mission of the King's Fund is to find practical ways of assisting London leaders and its people in addressing the tremendous challenges of achieving desirable change in this system. For over 20 years (prior to joining the Fund he was Secretary to the Special Trustees at St Thomas's Hospital), this agenda has been central to Robert's interests. Soon after arriving at the Fund, for example, he took personal responsibility for the Fund's London Committee and its programme of work (still continuing through the London Health Partnership) to improve urban primary care. He also initiated and served on the two independent Commissions on the future of services in the capital, the second of which has recently reported on *Transforming health in London.*[1]

Robert brings a great deal of wisdom to these challenges. He appreciates more than most that the 'problem' of London's health system is just as much about *how* informed change is to be achieved as it is about *what* future patterns of services will be required to meet changing needs. Two years after the first Commission's report, when the Government was still implementing the Tomlinson recommendations with gusto, Robert attracted some unpopularity in high places by writing a personal commentary, *What next for London's health care?*[2] This argues persuasively that while a long-term programme of reform remains essential, it is equally essential that this is pursued in ways which re-establish trust, promote openness and foster learning from experience as change proceeds.

This brings me to a second important attribute. The philosophy of 'Let a thousand flowers bloom' is usually attributed to Chairman Mao. In Robert's hands, I assume that Quakerism played a larger part in an approach to leadership grounded in the belief that if you bring people together and trust in their capacity for 'responsible creativity', then good things will happen. Certainly, at the King's Fund, Robert has relied heavily on trying to provide favourable

1292 Master 5/11/97 11:26 am Page 135

conditions for a plurality of talents to engage productively with the Fund's mission and the opportunities offered by what is happening in the Fund's environment. More generally, he manifests a healthy scepticism about prevailing fads in policy-thinking or new technological fixes if too much is claimed for their ability to offer protection from the inherent uncertainties in anything so complex and conflict-ridden as future developments in health care. His preference instead is to put faith in the capacity of people to act with integrity and thoughtfulness in together building a different future and learning to live with the anxieties involved.

The third aspect of Robert's contribution I want to highlight complements the previous two. For many years, a regular answer to the question 'Where is Robert today?' has been 'In Court'. His service as a magistrate in South London is in part an expression of his commitment to the responsibilities of citizenship and in part a practical manifestation of an interest in justice, also represented, for example, in his celebrated paper on quality in health care.[3] More subtly, however, I think it also represents a belief in the importance, not least for the leader of an élite foundation with a mission for London, of keeping in direct touch with the everyday experience of 'ordinary' Londoners, particularly those suffering most from disadvantage. A Magistrate's Court offers constant reminders of Joan Baez's refrain that 'There but for fortune go you or I'.

This essay picks up the London focus and each of these themes to address the question of how the transformation of London's health system to meet the needs of Londoners into the 21st century might be achieved in the coming years. Of course the views which follow are mine, not necessarily Robert's. They are based on a series of empirical studies of recent experience of introducing change that my colleagues and I undertook for the second London Commission, published as *London health care: rethinking development*.[4]

My starting point is the questions of why significant change is needed in London and also why it is so difficult. Taking a lead from the themes outlined above, I then explore selectively the voluminous social science literature on large-scale change to identify a set of

1292 Master 5/11/97 11:26 am Page 136

ideas which might be helpful to London leaders. The argument is that neither traditional conceptions of public sector planning nor the operation of market incentives fit well with the need for continuing evolution in both the organisation of health services delivery and forms of professional practice. Rather, progress depends on establishing a new culture and pattern of relationships in the health system as a whole which promote the *autonomy and self-organisation in the swamp* of the subtitle.

The swamp here is the complex and uncertain environment in which judgements about positive action must necessarily be made. Autonomy refers to the sense of individual authority (and therefore responsibility) required from a wide range of formal and informal leaders, to act on their own understanding of what is required to do better and learn from reflecting on this action as change proceeds. Self-organisation is the principle by which such autonomous leaders, confronted with the dilemmas of the swamp, work together often across existing boundaries, to establish more adaptive ways of organising and delivering responsive services to people and communities. Weaving these ideas together, it is possible to outline a new model for achieving transformational change and identify some of the conditions required for its application in London.

Unsurprisingly, there are significant cultural and political barriers to introducing these new ways of thinking and acting. If organisations are often memorials to old problems, conventional ways of thinking about organising provide the intellectual and emotional defence of these memorials. Writing in the summer of 1997, there is however a significant opportunity in London for reflecting on the experience of the past five years and discovering better ways forward. Both the new Government and, more specifically, its London Strategic Review open a window to different approaches to the next phase of health sector development. The essay concludes therefore with some implications for different types of leadership in London, including the future contribution of the King's Fund itself.

1292 Master 5/11/97 11:26 am Page 137

Addressing the London 'problem'

Across the developed world there are powerful pressures for change in health care systems, which make traditional patterns of services and the institutions providing them unstable. Most important are demographic changes, continuous innovation in treatment technologies and rising public expectations for high-quality services. New thinking about the shape of local services involves a fresh emphasis on primary care, pursuit of better co-ordinated support to enable people with chronic illnesses to sustain ordinary lives in the community and reshaping acute services to increase specialism and concentration in some, while others are delivered closer to home. There is also more explicit recognition of the growing inequalities in health in economically divided societies and of the need for priority-setting, as reasonable aspirations outpace the commitment to increasing public expenditure. At the same time the complexity of the interconnections between these pressures and their impacts makes prediction more than a few years into the future inherently risky. To quote Rudolf Klein, 'The only certainty is uncertainty.'[5] (p.8)

All this is of great importance to London as both the home for 7 million people and the UK's major centre for health services, education and research. Over the last century more than 20 separate inquiries have documented the need for significant change in the pattern of London services and institutions, largely with disappointing results.

In the 1990s, this reform agenda has focused on the three interrelated objectives of strengthening primary, community and continuing care; rationalising acute hospital services to improve quality and efficiency; and reorganising medical education and research into a small number of major academic centres. Although simply stated, the changes involved here are more profound than just the rearrangement of services and facilities: they imply a significant, medium-term *transformation* in which many people receiving care and many people providing it will be doing different things in different ways.

1292 Master 5/11/97 11:26 am Page 138

This agenda would be challenging anywhere but it is considerably more challenging in London. The size and diversity of London, its administrative complexity, the history of institutional parochialism and the tendency of local conflicts to be magnified by closeness to Westminster and the national media, all add to the difficulties for conventional approaches to securing planned change.

All major change programmes in public services pose difficult policy dilemmas, for example in balancing:

the Government's ultimate accountability and responsibility for fairness	*and*	the need for local discretion to ensure appropriate responses to diversity;
the authority of formal leaders to take action	*and*	the need to secure widespread commitment if this action is to be successful;
the requirement for conformity to agreed standards on some issues	*and*	the need for creativity to invent new 'solutions' on many others.

In the case of London's health system in the 1990s, three publications were particularly influential in shaping thinking on the response to these dilemmas: the report of the first London Commission,[6] the 'Tomlinson' report[7] and the Government's response to this, *Making London better*.[8] Each of these argues that change on the scale required in London needs a combination of clear strategic direction (e.g. 'strategic guidance ... and coherent system-wide implementation';[6] 'managed firmly'[7]) with some form of decentralisation (e.g. 'driven locally and, above all, by patient needs'[8]). However, the specific proposals in these reports leave unclear how these top-down and bottom-up elements are to be integrated. Indeed, the two official reports put all the emphasis on a traditional planning model relying on ministerial decision-making supported by a high-level implementation agency tackling major tasks on very short timescales.

The practice has turned out to be quite messy. The official approach to addressing the multiple London challenges has been based on

1292 Master 5/11/97 11:26 am Page 139

what, at least initially, was a concerted package of top-down planning and promotional initiatives combining quite detailed prescription from the centre, active political leadership from the Secretary of State for Health, ear-marked funds both to promote innovation and cover the costs of transition, and new machinery for negotiating change across local and institutional boundaries (notably the short-lived London Implementation Group).

However, this London-focused package was being implemented alongside a wide range of other national policy initiatives aimed at both decentralising control in health and social services through introduction of the internal market, while retaining strong central prescription on all kinds of specific issues (e.g. the Calman reforms to medical staffing; the Culyer changes to R&D funding and, perhaps most significantly, the Private Finance Initiative on access to capital for investment).

Moreover, all this was only 'one side of the coin'. There were also the myriad initiatives taken by individuals and groups throughout the London health system on their own authority – sometimes responding to the official agenda, sometimes pursuing other goals – which were arguably just as much the real stuff of sustaining or changing existing arrangements.

At first sight, this combination of official measures and informal initiative suggests a potent mixture. Undoubtedly, a lot has happened over the last five years, as the second London Commission has sought to document.[1] The evidence collected by the Commission, however, also casts considerable doubt on the extent of progress in tackling the medium-term agenda required to serve Londoners better and the sustainability of some positive developments (particularly those designed to shift the balance between hospital and community services). It thus raises serious questions about whether these approaches to change are likely to be successful.

Perhaps with hindsight, we can see that while there is much to be commended in the high-level political commitment to reshaping

1292 Master 5/11/97 11:26 am Page 140

London institutions and the specific London policies, the ways change has been addressed also have major deficiencies.

While different types of change have different requirements, this mixture of centralisation and decentralisation, planning controls and market freedoms, has appeared poorly related to the real challenges. The scope for central planning and decision-making in change of this complexity was overrated. Health authorities and other agencies have been hard put to establish (let alone implement) a coherent local agenda in the face of a plethora of central policies and directives (some of which, like the private finance initiative, inhibited the changes that had been agreed).

At the same time, there has mostly been the wrong kind of decentralisation: market fragmentation and competition have been poorly equipped to handle politically and professionally sensitive changes over quite long timescales. In particular, the creation of NHS trusts as cost centres, often based on existing institutions, has added to the difficulties of securing a population-centred approach to service development across existing agency and professional boundaries.

Meanwhile the lip-service to philosophies which recognise the importance of both staff and public involvement in shaping and delivering change has often been difficult to realise, as decisions were taken 'behind closed doors', conflicts suppressed and public leaders turned into hostile bystanders. Change in management became the enemy of the management of change, as organisational turbulence undermined the continuity necessary to build confidence in the shift to new patterns of provision. All this and the intended pace of development have also meant that there have been inadequate arrangements for learning from experience across London as change has occurred.

Are there other ways of thinking about achieving strategic change in situations of this complexity which could assist London leaders in tackling better the massive agenda for development over the next five years? I think so.

1292 Master 5/11/97 11:26 am Page 141

Rethinking development

The popular dictum 'There is nothing so practical as a good theory' is usually ascribed to Kurt Lewin. It is certainly the case that if, as leaders and participants, we are to orient ourselves in complex and changing systems, we need the capacity for what Gareth Morgan describes as 'imaginization',[9] i.e. the use of theories and metaphors to find new ways of seeing, understanding and shaping our actions. Necessarily, all such metaphors are partial in the illumination they offer: in practice people need to be able to draw on a variety of perspectives which are themselves amended and extended through experience.

Social science, and in this case the extensive multidisciplinary literature on large scale change, provides for the systematic development of these theories, often drawing on the metaphors used by practitioners and in turn being selectively reincorporated into their repertoires. From this extensive literature, I want to introduce five interrelated sets of ideas (and their principal authors) which seem to have particular relevance to the London 'diagnosis' above.

Donald Schön: learning for action in a rapidly changing world

Nearly 20 years before the popularisation of ideas about *Thriving on chaos*,[10] Donald Schön set out a powerful critique of the failure of public agencies to adapt to the increasing rate of environmental change in *Beyond the stable state*.[11] Hierarchical forms of organisation and the separation of policy-making from implementation were no longer adequate to the challenges public agencies were established to tackle. Rather, Schön argues, organisations need to become *learning systems*, capable of bringing about their own continuous transformation through learning at the periphery of their activities and diffusing this learning through a wide variety of networks.

His subsequent work explores the implications of this view for the professional practice, for example, of policy-makers, managers and clinicians. In all these areas professional knowledge seems mismatched to what is increasingly required in everyday situations of complexity, uncertainty and conflicting values. Learning to cope with these

1292 Master 5/11/97 11:26 am Page 142

conditions requires a shift in emphasis from the application of technical rationality (which can be taught) to the art of *reflection-in-action* (which can only be learned from experience). Schön writes:

> In the varied topography of professional practice, there is a high, hard ground where practitioners can make effective use of research-based theory and technique, and there is a swampy lowland where situations are confusing 'messes' incapable of technical solution. The difficulty is that the problems of the high ground ... are often relatively unimportant ... while in the swamp are the problems of greatest human concern. Shall the practitioner stay on the high, hard ground ... ? Or shall he descend to the swamp where he can engage the most important and challenging problems if he is willing to forsake technical rigour?[12] (p.42)

Henry Mintzberg: emergent strategy for public policy

Through a great variety of empirical studies of what happens in large organisations, Henry Mintzberg has developed these ideas with particular reference to *The rise and fall of strategic planning*.[13] He shows convincingly that the claims made for large-scale planning, not least in government, are largely unwarranted.

However, there is no need to throw out the strategy baby with the planning bath water. Defining strategy as the pattern that can be identified in many actions over time in a policy area, Mintzberg argues that it is useful to distinguish (as poles on a continuum) between two broad types of strategy: *deliberate* and *emergent*. Deliberate strategy is precisely the traditional conception of top-down planning, based on 'rational' analysis, which precedes implementation and becomes realised (or does not, as the case may be!). *Emergent strategies* by contrast can be recognised in what is achieved, but rather than being formulated in advance, emerge through a variety of processes characterised by flexible responses at the grass roots and the capacity within the organisation or system to learn from these responses in ways which give increasing shape to the patterns thus produced.[14]

What the empirical studies show is that in practice all policy-making involves a combination of deliberate and evolved action, in different

1292 Master 5/11/97 11:26 am Page 143

mixes: for example, near the middle of the continuum are 'umbrella strategies' in which the 'top' provides guidelines or boundaries for local action, initiative is encouraged and patterns emerge within these boundaries which are carefully monitored.

Moving from description to prescription, the significance of these distinctions is to suggest that different types of change are likely to unfold in different ways under different conditions: in seeking to promote change therefore it is important to choose 'horses for courses'. Deliberate strategies are likely to be appropriate where the environment is stable, information for planning can be assembled centrally, 'solutions' can be standardised and people at the delivery end can be expected at least to acquiesce. Mainly emergent strategies, however, are appropriate in complex and unpredictable circumstances, where the required intelligence is located deep inside the system and action is dependent on motivated local leadership.

Margaret Wheatley: self-organisation to produce order out of chaos

The idea of emergence has been further developed by Margaret Wheatley among others, from a very different intellectual basis.[15] She points out that much organisational thinking is still grounded in a mechanistic and deterministic Newtonian view of the world. If we must look to natural sciences for metaphors, she argues that there is much more to learn from 20th century sciences such as quantum physics, chemistry and chaos theory, which offer a quite different view – of the need to look at the whole rather than the parts of natural systems, to appreciate the inherent uncertainty and unpredictability in much of the natural world and to see *self-organising systems* at work. Translating these ideas into organisational life she writes:

> What leaders are called upon to do in a chaotic world is to shape their organisations through concepts, not through elaborate rules or structures.[15] (p.133)

Ralph Stacey[16] has applied these ideas to the challenges of achieving large-scale change. He argues that organisational success requires the simultaneous practice of 'ordinary' and 'extraordinary management'. The former refers to the day-to-day management of existing services and their incremental improvement (very important, for example, in maintaining quality in public services). *Extraordinary management* by contrast is required to discover and implement radically new ways of doing things (i.e. to bring about the transformation of existing services).

Metaphors from the new sciences suggest that such transformations can be understood as seeking *order emerging from chaos*[17] through allowing but containing instability in existing arrangements, fostering informal self-organising networks and new alliances across agency boundaries, mobilising diverse perspectives (not just 'the usual suspects') and encouraging the active search for innovation.

John O'Brien: starting from individual experience

In human services it is of course essential that strategic change and service development are informed by, and ultimately tested against, the experience of people using these services. Writing about the last weeks of my father's life, I have myself documented the complexity and sensitivity of the professional and community action involved in this most common and unique of human experiences.[18] Working mainly on the challenge of how people with serious disabilities can get the opportunities and support to lead a rich life in the community, John O'Brien has illuminated the nature of the leadership required 'close to the ground' in tailoring support to individual needs.

He suggests that leadership entails encouraging attention to responsible visions of desirable futures for people and working to clarify the values which underpin these aspirations, discovering ways of working which enable staff to pursue these visions and relating outwards to generate the resources required to undertake this work. The focus on individuals further entails getting to know people using services well and creating small problem-solving networks, with and around the person, prepared to take action to

1292 Master 5/11/97 11:26 am Page 145

move towards these better futures in the community. Most important, however, is the investment in learning which *embraces ignorance, error and fallibility*.[19] By showing the humility to listen to these 'three teachers' – ignorance about all that might be possible, error in working most effectively and fallibility in recognising the limits to professional services – organisations can become more competent in all these functions.

Eric Miller: autonomy and negotiation in developing large systems

Eric Miller has been the leading exponent of the distinctive Tavistock Institute approach to organisational change over more than 30 years. As the title of his overview of this work, *From dependency to autonomy*,[20] suggests, a central aim of this approach has been assisting people to gain greater influence over the things which affect them. A second key element has the been use of the biological analogy to examine individual and organisational life as 'open systems', i.e. as interrelated sets of activities or functions within some identifiable boundary which interact with each other and with the wider environment.

Autonomy at the individual level can be understood in terms of developing greater maturity in understanding and managing the boundary between the person's inner world (of values, intentions and anxieties) and the realities of the external environment. But the same ideas can be applied at larger system levels as, for example, in much of the early Tavistock work to establish autonomous work groups in industries like coal mining.

Miller has applied these ideas to change strategies in very large public systems, notably a massive programme of integrated rural development in Mexico. He argues that for development to become self-sustaining, the people in each local community had themselves to be committed to the programme:

> Each community needs to become a resilient system, capable of managing its own development both internally and in interaction with external systems.[21] (p.27)

In this context, neither 'top-down' (i.e. central planning) nor 'bottom-up' (i.e. entirely locally driven) methods of securing change are likely to be successful. Rather, Miller suggests a *negotiating model of central/local relationships* as a middle way, involving a direction-setting and regulatory role for the centre, an active development role for local communities, and a set of relationships between the two based primarily on negotiation and mutual adjustment. Thus this model offers a means of recognising legitimate national and political interests, while also promoting the collaboration and autonomy required to respond creatively to diverse local aspirations.

London implications

This has been only a brief detour into the relevant literature but our own empirical studies of change indicate that many of these insights are likely to resonate with the experience of London leaders seeking to learn from recent events. Moreover, as we have described in more detail elsewhere,[4] it is possible to weave these insights together to suggest a significantly different approach to transforming London's health system in the next five years. This has six main elements.

First, it will be important to draw from recent experience a better understanding of the nature of complex change in health systems and how different types of change unfold in different circumstances so as to tailor change initiatives to these different requirements. In particular, it will be necessary to distinguish changes which by their scale and sensitivity (e.g. reconfiguration of acute hospitals) require explicit political sanction from the many other service developments where there is greater local freedom; changes which are sufficiently definable in advance (e.g. the formula for fair resource allocation) to be planned centrally from all those whose complexity requires an 'umbrella strategy' with emergent local responses; and incremental changes (e.g. to improve standards in general practice) which can be delivered by ordinary management from more radical innovations (e.g. to shift the boundaries between hospital and community services) where 'extraordinary management' may be essential.

1292 Master 5/11/97 11:26 am Page 147

Second, Government will need to take the lead in developing a 'negotiating model' of central/local relationships sensitive to these different requirements – i.e. emphasising the role of the centre in setting broad directions for local interpretation, defining relevant parameters and promoting the conditions for local adaptability (notably, by moving away from the fragmentation of the internal market towards a new framework which fosters collaboration), while encouraging a more autonomous role for local agencies, wherever possible working in partnership.

Third, these partnerships will in turn be important in fostering new ways of working across existing organisational and professional boundaries to mobilise the creativity and diversity required to achieve transformation in the patterns of local services to meet changing needs (e.g. as proposed on a large scale in the 'Health Action Zones' or more modestly to improve the integration of services to particular 'client groups' such as older people with chronic illnesses).

Fourth, it will be necessary to strengthen the participation of the full range of local stakeholders in these change processes so that service developments gain the commitment and incorporate the 'hands-on' knowledge of those who deliver and receive services and are tailored to reflect cultural and other forms of local diversity.

Fifth, running through all these points is the need to develop and sustain more effective, locally rooted leadership, both formal and informal, capable of challenging old assumptions, articulating new visions, building support for different forms of practice and helping people 'work through' the anxieties always involved in significant change.

Finally, the next phase of health system development will require an enhanced commitment to learning from experience as change unfolds (e.g. through providing safe forums for reflection and mutual aid across agencies and localities) with a particular emphasis on making service development 'people centred', i.e. starting from individual experiences in constructing better ways of doing things and, conversely, testing more global propositions by their outcomes in the lives of intended beneficiaries.

1292 Master 5/11/97 11:26 am Page 148

This is, of course, no more than a sketch of a different way of thinking about achieving development. It is, however, part of the philosophy underpinning many of these insights that any new model of strategic change cannot be fully prescribed in advance but has instead to be created through the reflection, interaction and reflection-in-action of people with different responsibilities within the London health system.

Four broad sets of stakeholders seem particularly important here: ministers and their advisers, health sector managers, clinicians and local representatives of Londoners themselves. Each faces a different combination of opportunities and difficulties in shaping their future contributions.

The new Government has both the prime responsibility and the moral authority to renew the NHS through an emphasis on collaboration in delivering public health goals. Ministers need, however, to avoid the pitfalls of assuming, even with a huge parliamentary majority, that appropriate change can be delivered from the 'top' downwards or, given Labour's close identification with the NHS, of being too cautious to take the political risks associated with real innovation.

Managers, by virtue of their training and experience, should be most familiar with alternative ways of thinking about achieving change, but even so it would be a mistake to underestimate management investment in hierarchical control systems and implicit belief in the power of technical rationality to deliver 'solutions'.

Clinicians (i.e. medical, nursing and other 'front line' professionals) are likely to welcome greater recognition of their essential creative input to finding better ways of providing integrated, patient-centred services. However, they do not always show the same sophistication in understanding organisations as they do in appreciating the complexities of illness patterns and are sometimes predisposed to defend, rather than work across, existing boundaries.

1292 Master 5/11/97 11:26 am Page 149

Community representatives are similarly keen to be genuine partners in local dialogue but, after many years of doubtful influence, can easily be mobilised in the stance of 'the opposition which does not seek to govern'.

In the words of Sheryl Crow, 'No one said it would be easy'. The current 'window of opportunity' could, however, be used to establish greater confidence in the capacity of government and local leaders to work together to deliver positive change in London and thus establish a 'virtuous circle' of growing success. In turn, this would be one element in the larger task of (re)building a mature democracy fit for the 21st century.

There is also a very significant challenge here for the King's Fund itself – to match its distinctive contributions to policy analysis, action research and community development to priorities in the London change agenda and strengthen its role as the main node in a pan-London learning system designed to increase the capacity of London leaders to exercise *autonomy and self-organisation in the swamp*. As the King's Fund enters its second century of service to Londoners, success in this challenge would be a fitting tribute to Robert Maxwell's heritage.

Postscript. *Donald Schön, whose work is described here and who was a distinguished King's Fund International Visiting Fellow, sadly died while this book was in press. This essay is also offered as a very modest expression of appreciation for the inspiration he provided for so many of us.*

1292 Master 5/11/97 11:26 am Page 150

References

1. King's Fund London Commission. *Transforming health in London*. London: King's Fund, 1997.
2. Maxwell RJ. *What next for London's health care?* London: King's Fund, 1994.
3. Maxwell RJ. Quality assessment in health. *British Medical Journal* 1984; vol. 288, 12 May, 1470–2.
4. Towell D, Best G, Pashley S. *London health care: rethinking development*, London, King's Fund, 1997.
5. Klein R. *Coping with uncertainty in hard times: political and social factors in health futures*. London: King's Fund, 1996.
6. King's Fund London Commission. *London health care 2010: changing the future of services in the capital*. London: King's Fund, 1992.
7. Tomlinson B. *Report of the Inquiry into London's Health Service, Medical Education and Research*. London: HMSO, 1992.
8. Department of Health. *Making London better*. London, HMSO, 1993.
9. Morgan G. *Imaginization: the art of creative management*. London: Sage, 1993.
10. Peters T. *Thriving on chaos*. New York: Knopf, 1987.
11. Schön D. *Beyond the stable state*. London: Temple Smith, 1971.
12. Schön D. *The reflective practitioner*. London: Temple Smith, 1983.
13. Mintzberg H. The *rise and fall of strategic planning*. Hemel Hempstead: Prentice Hall, 1994.
14. Mintzberg H, Jorgensen J. Emergent strategy for public policy. *Canadian Public Administration* 1997; 30(2):214–19.
15. Wheatley M. *Leadership and the new science*. San Francisco: Berret-Koehler, 1992.
16. Stacey R. *Strategic management and organisational dynamics*. London: Pitman, 1993.
17. Stacey R. Strategy as order emerging from chaos. *Long Range Planning* 1993; 26(1):10–17.
18. Towell D. Revaluing the NHS: Empowering ourselves to shape a health care system fit for the 21st century. *Policy and Politics* 1996; 24(3)3:287–97
19. O'Brien J. Embracing ignorance, error and fallibility: competencies for leadership of effective services. In: Taylor SJ, Biklen D, Knoll J. *Community integration for people with severe disabilities*. London: Teachers College Press, 1987.
20. Miller EJ. *From dependency to autonomy*. London: Free Association, 1993.
21. Miller EJ. *Integrated rural development: a Mexican experiment*. London: Tavistock Institute, 1995 (First published in Spanish, 1976).

FOREWORD

to

TOWARDS A FULL LIFE
Researching policy innovation for people with learning disabilities*

Every once-in-a-while, a book comes along which offers the potential for major development in social policies and, more importantly, renewal of our collective energy to improve the well-being of fellow citizens who are the focus of such policies. This is such a book.

The last twenty years in Britain have hardly been characterised by much government inspired effort to strengthen communities and ensure the inclusion of people most at risk of disadvantage: rather the reverse. Perhaps the single most notable exception has been the All Wales Strategy (AWS) for people with learning disabilities. Launched by the Secretary of State for Wales in 1983, the AWS was a visionary initiative to secure for people with learning disabilities in Wales a full life in the community, growing, living and working with their mostly non-disabled family, friends and associates. Moreover, unlike many other well-intentioned policies, this initiative was led from the centre, backed by significant extra public resources, sustained over more than a decade and made the subject of a major research evaluation - the basis for this book.

Published now, as the new government's transformational intent is beginning to take shape, the detailed assessment of the AWS which follows is important for three main reasons. First, whatever the progress in Wales since 1983, there is clearly still a long way to travel *Towards a full life* for people with learning disabilities and their families. Indeed as a more general review of the U.K. situation expressed this (Mental Health Foundation, 1996):

> *Although (people with learning disabilities) are increasingly living in ordinary communities, many live in poverty, have little meaningful activity during the day, few friends and no real hope for change in the future.*

The book offers an informed and persuasive agenda for a wide variety of people in Wales and beyond to re-engage with the challenges highlighted by this seemingly depressing diagnosis.

Second, people with learning disabilities are only a small part of the larger range of people who need the opportunities and support associated with what we have chosen to call 'community care', itself the focus of recent major reform (the NHS and Community Care Act, 1990) apparently reflecting some of the same goals as the AWS. But the evidence of this research is that these wider policies have been partly responsible for undermining the AWS and are themselves in need of serious reappraisal if their principled rhetoric is to be made more meaningful in practice.

---

* Felce, D., Grant, G., Todd, S., Ramcharan, P., Beyer, S., Mcgrath, M., Perry, J., Shearn, J., Kilsby, M. and Lowe, K. *Towards A Full Life* Oxford, Butterworth Heinemann, 1998

Third, the new government has made tackling exclusion and inequality more generally a key element in its contract with the British people, as part of (re-)building a society based on interdependence and mutual responsibility: requiring new approaches to policy implementation which are outcome-oriented, holistic and delivered with the participation of all the people affected. Arguably the AWS was a modest forerunner of such ambition: it will be vital to learn from its strengths and weaknesses if wider disappointment is to be minimised. Again, this book is illuminating on the requirements for social changes which go beyond reshaping services to strengthening communities.

The genesis of policy promise

To understand the significance of the AWS, it is necessary to start further back. It was in the late 1960s, when many of us were enjoying growing affluence and new opportunities, that public attention was drawn to the very different experiences of some of our fellow citizens by the first of what was to become a series of institutional scandals: the mistreatment and exploitation of patients at Ely Hospital, Cardiff. It is a sad commentary on the concern of the rest of us that it took these scandals to highlight what with hindsight is only common sense: if large numbers of very vulnerable people are segregated for life in isolated and underfunded institutions, they are likely to be denied key aspects of the human rights others take for granted. However, the scandals of a generation ago did open up the possibilities for reform, even if far too slowly delivered.

As one example, the King's Fund itself decided in 1970 to make raising professional awareness and improving standards in learning disability services a major focus of its work. This was one of several such endeavours, but by 1978, when I joined the Fund as Community Care Director, it was already clear that something more radical was needed. The scandals had not stopped: indeed the Inquiry at Normansfield where my sister Pat was living had just reported. Significant investment, particularly through the NHS (but also in Social Services and later through Social Security funding of residential care) was being allocated but often to establish new building-based services which seemed likely to replicate some of the weaknesses in those they were replacing, even if in nicer physical environments. (At Normansfield, the 'price' of the Inquiry was extra revenue and two million pounds of capital - at late 'seventies prices - to build 24-place 'bungalows' and a day centre in the hospital grounds: they stand now as empty monuments to inadequate imagination, following the hospital's closure in 1997.) And throughout all this, the majority of adults with learning disabilities continued to have no option except to live in the parental home for most of their lives.

The King's Fund response to this situation, again allied with many other progressive interests, was to launch - and indeed sustain throughout the 1980s - the *An Ordinary Life* (AOL) initiative, as a focus for rethinking the opportunities and support which should be available to people with learning disabilities, producing evidence-based design guidance for the necessary supports to community living, mobilising and assisting local change strategies and learning from experience (King's Fund, 1980). You might think that the goals of this initiative as expressed in its title were modest

enough, but then, as now, really delivering on its core principles was a substantial challenge.

The initial focus for this work, partly because of the availability (and waste) of capital was ensuring the access of people, irrespective of the severity of their disabilities, to ordinary housing and support in the community (i.e. in your street and mine). This was followed by similarly detailed attention to family support, employment, leisure and the strategies required to achieve comprehensive patterns of opportunities and support to all the people in defined populations (Towell, 1987; Towell and Beardshaw, 1991).

In our early conferences to share this thinking and learn from local experiences across Britain, we had to look for practical demonstrations of well-developed supports to community living for people with severe disabilities to Scandinavia and North America (the achievements in Eastern Nebraska being a particular source of inspiration). We also regularly invited contributions (for example on person-centred planning) from leaders of the NIMROD project then taking shape in Cardiff (and itself one delayed response to the Ely Inquiry) which promised to be the first demonstration of comprehensive provision for a small population of precisely the kind we were advocating.

It was because of the AOL initiative and the NIMROD connection that I found myself, probably in 1981, invited to Cardiff to meet Tony Pengelly, a senior official in the Welsh Office, to discuss the prospects for an AWS based on the same philosophy. This began what has become a long term interest in Welsh progress. A little later, as a member of the Department of Health's Research Liaison Group, I was involved in considering the proposals for AWS evaluation and became a member of the group which linked the Welsh Office to the research teams. From this I graduated to become a member of the Secretary of State's Advisory Panel for the Strategy (AWAP), serving for seven years through the period of 'high tide' and after.

Mr. Pengelly had recently transferred from defence procurement to health. This was fortunate in both that he was probably used to ordering and cancelling battleships and not weighed down by too much knowledge of conventional thinking in the field of learning disabilities. He was sure he could persuade Ministers to make the 'financial space' for a major initiative (surprising though it may seem now, from savings in acute hospital spending) and had himself been convinced of the importance of radical change in the lives of people with learning disabilities. He was however understandably concerned about feasibility. I was enthusiastic about the proposed direction of travel (and the model of value-based government leadership it would offer elsewhere in the United Kingdom!), but I also remember emphasising the need to complement the central policy framework with real investment in strengthening the capacity of local agencies to deliver on the strategy, including its commitment to fully involving people with learning disabilities themselves. (Both these issues were to become recurrent themes of later discussions in the AWAP:AWAP, 1989; AWAP, 1991.)

Ministers duly were persuaded and indeed the Secretary of State himself identified with the launch of the Strategy in 1983 with its explicit commitment to the three AOL principles (Welsh Office, 1983):

- *people with a mental handicap have a right to ordinary patterns of life within the community;*
- *people with a mental handicap have a right to be treated as individuals; and*
- *people with a mental handicap have a right to additional help from the communities in which they live and from professional services in order to enable them to develop their maximum potential as individuals.*

Lessons from experience

So much is history. The book takes up the story of what happened to the AWS over the following 13 years, the evolving arrangements for local implementation and its impact in the lives of Welsh people with learning disabilities, their families and communities.

For what is probably the most sustained research programme ever mounted on a single social policy issue, the Department of Health had the good sense to commission two research teams, not just one in the North and one in the South, but also bringing different perspectives to this work. The Cardiff team works broadly within the 'applied behavioural science' paradigm, illuminating the relationships between structure, process and outcome in service development. The Bangor team are mainly sociologists, with a keen insight into the place of services in family and community life. Brought together here, these two perspectives offer a unique appreciation of what has been a complex undertaking. The book as a whole provides a mine of evidence, ideas and as yet unresolved questions for all those concerned to do better in securing a full life for people with learning disabilities and their families.

In every area of the Strategy there are important findings. The AWS has achieved a major expansion in support to families, but have these new domiciliary supports been flexible enough to respond to the families' own views of what would be most helpful? It has spread through Wales a strong commitment to offering small homes to people in ordinary houses but have staff been sufficiently prepared to offer effective support to the tenants with more severe disabilities (and has policy still left untouched the question of when adults with learning disabilities should be given the opportunity to move out from their parents' homes)? The AWS has greatly widened the opportunities for day-time activities but have real jobs been too small a part of this and what can be done about the 'benefits trap' which continues to make employment a risky option for most people? There has been a related expansion in leisure activities but have these given too little attention to the requirements for people really to join in with other members of the community? It has taken a long time to build the significant consumer involvement in shaping and reviewing local services (for example there has been major growth in self advocacy groups) but how fragile are these arrangements to changing circumstances like the disruption engendered by local government reorganisation? And so on.

In turn these detailed findings raise some fundamental questions. By the standards of British public administration, the AWS has been a bold and well-formulated initiative, pursued with considerable energy and persistence. Even so, it can still be asked whether it really has been a *strategy* in the specific sense of seeking to plan for the whole of the eligible population in each locality within some plausible resource

envelope, bringing in all the relevant parties (for example, those responsible for the people and resources still in the traditional hospitals). Similarly, while the local agencies and their community partners have undoubtedly achieved a great deal, it can still be asked whether, notwithstanding the very clear statement of principles with which the AWS began, too much attention has been given to the role of *services* in securing the presence of people with learning disabilities in their communities and not enough to 'opening up' the opportunities and mobilising the *natural supports* required for their more meaningful community participation.

Looking forward

Of course, in the words of Sheryl Crow, 'No-one said it would be easy.' Indeed the AWS architects envisaged from the outset that after the first decade we would still be travelling hopefully, rather than having arrived. Nevertheless, if an optimist is someone who sees the glass as being half-full, readers may conclude that the research teams are more inclined to a 'half-empty' assessment. The central importance of this book is that it offers all those involved the evidence for a review of what has been achieved and the ideas required to reinvigorate pursuit of the original AWS aspirations.

A key lesson from Wales, as elsewhere, is that fundamental change in the position of people with learning disabilities in our society cannot be achieved by government on its own, by local agencies and paid staff on their own, by people and their families on their own, or by communities on their own. Rather progress requires all to become partners in informed action.

One contribution now would be for the new Secretary of State, perhaps in the context of the government's wider commitment to tackling social exclusion, to ask his officials and others involved to produce and publish a Welsh Office review of the implications of this research for future policy and strategy. (For a long time in the research liaison group and AWAP, I encouraged officials to produce a regular account not just of what research was being done and its findings, but also what impact these had on Welsh Office policies. It would be timely now to do this for the whole research programme so well summarised in this book.)

Whether or not government takes the initiative, a second contribution would be for all the new unitary local authorities, with assistance from their professional staff and local partners, to review performance against the findings here on the requirements for technical competence in service development. The expectation from this research must be that they will be able to identify ways of improving significantly the quality of life for people with learning disabilities and their families even within existing resources. At the same time there would be merit in scanning the government's wider policy agenda, for example on Welfare to Work, Lifelong Learning, the expansion of Social Housing, etc. to ensure, in the words of the title of another AWAP publication (1996) that these policies *Include me in!*

Third, people with learning disabilities, their friends and advocates may take heart from their achievements in recent years while keeping up the struggle to be properly heard and fully involved.

Fourth, all of us as citizens need to recognise our collective responsibility for building communities which welcome, and indeed benefit from the involvement of everyone - translating this practically into support for inclusive policies, in school, in work, at leisure, and our personal efforts to open up opportunities for people who are missing out.

Even better, if people in Wales are able to link these four contributions together, we should see not so much the dissipation of the AWS anticipated by the research teams but rather, in their words, a 'phoenix rising from the ashes'. Reading and reflecting on this book will be a good starting point for making it happen!

King's Fund
March, 1998

David Towell

References

All Wales Advisory Panel (1989). Proposals for the independent review of services for people with mental handicaps in Wales. Cardiff: Welsh Office

All Wales Advisory Panel (1991). Consumer Involvement And The All Wales Strategy. Cardiff: Welsh Office

All Wales Advisory Panel (1996). Include me in! Cardiff: Welsh Office

King's Fund (1980). An Ordinary Life. London: King's Fund

Mental Health Foundation (1996). Building Expectations. London: Mental Health Foundation

Towell, D. (1987). An Ordinary Life In Practice. London: King's Fund

Towell, D. and Beardshaw, V. (1991). Enabling Community Integration. London: King's Fund

Welsh Office (1983). All Wales Strategy for the development of sevices for mentally handicapped people. Cardiff: Welsh Office

SOCIAL INCLUSION AND COMMUNITY CARE

David Towell

(Paper produced for the journal *Management in Community Care* to mark the launch of the Social Inclusion Programme* at the University of London's King's College.)

The pursuit of concerted policies to build a more inclusive society, or more precisely, to tackle 'social exclusion', is arguably the 'big idea' of New Labour's first year in government. Most departments of government are reshaping their mainstream agenda, whether focused on educational achievement, welfare to work, urban regeneration, housing investment, social security reform or improving public health, to address poverty and exclusion as central challenges. A new unit in the Cabinet Office has the stimulation and coordination of these efforts as its mission. Moreover there is high level recognition that success in what is bound to be a long-term programme requires government to develop new ways of working which provide 'joined up solutions to joined up problems'.

What opportunities and challenges does this overarching policy agenda offer for improving what we call 'community care'?

Social inclusion policies: origins and intent

The government presents these policies as a radical departure from those of its predecessors and indeed as part of the elusive search for a 'Third Way' in British politics. There is however nothing new in the discovery and rediscovery of poverty in British society, dating back at least a century to the work of Rowntree, nor to recognition of its multi-faceted nature. And similar concerns are already being addressed through the European Union.

In richer countries, common factors driving these concerns include the impact of globalisation and monetarist economic policies on employment, particularly in traditional industries, and the associated patterns of growing long-term poverty. More than this has been increasing recognition of the association between modern poverty and a range of 'social problems' like family instability, rising crime and drug use, or put differently, the growing numbers of people who through low expectations and limited opportunities are deprived of the capacity to control their own lives. *Social exclusion* has come to be understood as the causes or processes which lead to these consequences.

It is arguable that the last government believed these consequences were either unavoidable or a 'price worth paying' for the benefits of free market economic policies. A plausible interpretation of the General Election result is that the public does not agree.

What is distinctive about the new policy context is the willingness of the government to put tackling social exclusion at the centre of its programme. The Prime Minister personally launched the Social Exclusion Unit (SEU) in a speech at a school in Lambeth under the title 'Bringing Britain together' (1):

> 'At the heart or all our work, however, is one central theme: national renewal. Britain rebuilt as one nation, in which each citizen is valued and has a stake; no-one is excluded from opportunity and the chance to develop their potential; in which we make it, once more, our national purpose to tackle social division and inequality.'

The broad range of mainstream policies adapting to this theme are noted above. In addition the SEU has made an early start on three specific challenges: reducing truancy and school exclusion, finding alternatives for rough sleepers and developing sustainable approaches to the inter-connected problems of the worst housing estates.

What is emerging from this work is a growing vision of what it means to be included, incorporating:

- being valued as an individual with a contribution to make;
- gaining support from family life;
- enjoying the conditions required for optimum health;
- acquiring understanding and skills through high quality education and training;
- accessing appropriate employment;
- having adequate housing in mixed communities and decent environments;
- living free from fear of crime and discrimination;
- engaging in a variety of social networks;
- exercising choice and participating as a citizen; and
- having the personal resources to do all these things.

The Prime Minister is also committing the government to reform itself to deliver on these aspirations (2). Long term prevention requires government to tackle causes not just symptoms. Success is to be demonstrated by greater fairness and better outcomes in peoples' lives. Problems are to be addressed holistically through partnership among many different agencies and the involvement of people affected. Local initiative is the key to progress. This progress is to be systematically monitored to show what works and what does not.

Taken at face value this is a bold agenda for action well into the next century, even if leaving important political questions, for example about the extent of redistribution and the need for more radical economic policies, as yet unresolved.

And Community Care

The language of 'community care' is currently devalued, partly because policies with this name have traditionally delivered rather less than they claimed, but more recently because government itself has taken to declaring 'care in the community has failed' as a very inadequate sound-bite to introduce its new mental health policies.

Readers of *MCC* will understand these terms instead as representing the history of aspirations to ensure that people disadvantaged by chronic illnesses and disabilities receive the opportunities and support required to lead full lives in the community, precisely as suggested by the ten point definition of *inclusion*, above. Progressive initiatives have long sought, for example, to enable children with learning disabilities to be included in local schools; adults with mental health problems to get the support necessary to hold down proper jobs; disabled people to be involved in community life through removal of the physical and attitudinal barriers to participation; and older people with chronic illnesses to get the support needed to continue living in their own homes.

Moreover, national and local strategies to pursue these objectives have emphasised the same processes for implementation (3). The focus on outcomes, an holistic approach, inter-agency partnership in problem solving, proper assessment of policy impact, etc. - seen, for example, in the better attempts at person-centred planning, care management and joint commissioning - are now to characterise the search for 'joined up solutions' more widely.

We can reasonably conclude therefore that the new government's mainstream strategies to achieve a more inclusive society have both a lot to offer and much to learn from the more specific ambition to ensure full lives in the community for people with long-term illnesses and disabilities.

Strengthening the connections

Of course it is still early days, and history suggests that policy intent is not the same as policy delivery. In each area of policy, initial proposals offer significant hope combined with important caveats, and on the ground there is still often a sense of embattlement as a consequence of tough public spending controls which spanned the last and present government's budgets (4).

Reviewing progress to date, there are five ways in which the necessary connections might be strengthened.

First, we must work hard to avoid the paradox of being *excluded from inclusion:* nationally, the Department of Health, supported by the SEU, needs to restate community care policies in the language of mainstream policies as well as identifying the specific kinds of support (which may differ across 'client groups') required to ensure people e.g. with mental health problems, are able to take full advantage of new opportunities. The same challenge exists locally, particularly in the context of the increasing emphasis on multi-sectoral strategies, like those being developed in the Health Action Zones.

Second, these joint strategies need to reflect what we have learnt over the years about the importance of starting from clear principles, building networks, engaging the 'whole system' of relevant provision and tailoring opportunities and support to each individual's preferences.

Third, we must go beyond the good intention to involve people to put the views and experiences of those who are excluded at the core of efforts to make a positive difference.

Fourth, we must ensure that the government's welcome emphasis on monitoring success is reflected in policy impact assessments which are carefully designed to identify progress for people with chronic illnesses and disabilities, measured against quality of life outcomes.

Finally, in making community care part of the mainstream agenda, we must recognise that real progress depends on the currently 'included' playing a full part in rebuilding community, opening up opportunities (e.g. at school, at work and in leisure) and supporting greater fairness: it is essential therefore that both government policies and local action make explicit the challenges (and benefits) to us all, not just the excluded minorities.

The Centres for Community Care and Mental Health Services Development at King's College, the latter now in partnership with the Sainsbury Centre for Mental Health, have a strong track record of action research, consultancy and network development relevant to improving the opportunities and support for people in the different 'client groups' which are traditionally the focus of community care policies, The new Social Inclusion Programme provides one overarching framework for integrating different elements of this work and linking it to the government's broader policy agenda. The programme will aim to assist people at risk of serious disadvantage, partners in local multi-agency strategies and government to find practical ways of addressing these five challenges and distill what is learnt from this experience as a resource to future policies for a more just and inclusive society.

Notes.

(1) This and other speeches and details of the Social Exclusion Unit programme are available on the SEU web-site, http://www.open.gov.uk/co/seu/seuhome.htm

(2) For a good account of these changes in the processes of government, see Mulgan, G. 'Social exclusion: joined up solutions to joined up problems' in Oppenheim, C. (ed.) *An Inclusive Society: Strategies for tackling poverty* London, IPPR, 1998.

(3) See, for example, Towell, D. and Beardshaw, V. *Enabling Community Integration* London, King's Fund, 1991.

(4) This point is sharply illustrated by comment on the Stockwell Park Estate, where the Prime Minister launched the SEU. See, Brown, C. 'Lights, Camera.....Cuts' *Community Care* 26 February, 1998

* Social Inclusion Programme
King's College Community Care Development Centre
Friar's House
157-168 Blackfriars Road
London SE1 8EZ

Tel: 0171 928 7994
Fax: 0171 928 4101

DAVID TOWELL: PUBLICATIONS 1978-1998

BOOKS

Enabling Community Integration: the role of public authorities in promoting an ordinary life for people with learning disabilities in the 1990s London, King's Fund, 1991 (with Virginia Beardshaw)

Managing Psychiatric Services in Transition London, King's Fund, 1989 (with Sue Kingsley and Tom McAusland).

An Ordinary Life in Practice: Developing Community Based Services for People with Learning Disabilities London, King's Fund, 1988 (editor)

Innovation in Patient Care: An action research study of change in a psychiatric hospital London Croom Helm, 1979 (with Clive Harries).

MONOGRAPHS

London Health Care: Rethinking Development London, King's Fund, 1997 (with Gordon Best and Steve Pashley)

Evaluating Primary Care Development London, King's Fund, 1997 (with Nick Mays, Virginia Morley, Sean Boyle and Penny Newman)

Include Me In! Enabling people with learning disabilities to lead a full life outside the home Cardiff, Welsh Office, All Wales Mental Handicap Strategy Advisory Panel 1995

Better Management, Better Health (Lepsi Management, Lepsi Zdravi): Final Report on the Czecho-Slovak Health Management Project, London, King's Fund College, 1993 (with Jo Ivey Boufford, June Crown, Sheila Damon, Antonio Garcia, John Mitchell and Jaume Ribera)

Consumer involvement and the All Wales Strategy Cardiff, Welsh Office, All Wales Mental Handicap Strategy Advisory Panel, 1991 (with Panel's Consumer Involvement Sub-Group)

Assessment and Case Management: Implications for the implementation of 'Caring for People' London, King's Fund Institute, 1990 (with Virginia Beardshaw)

Cinderallas Again? The Impact of Current National Policies on Opportunities and Services Available Locally to People with Learning Difficulties and Their Families London, IDC, 1990 (with IDC colleagues)

Towards a New Deal for People with Learning Difficulties in Tower Hamlets London, NDT, 1989 (with NDT colleagues)

Pursuing Quality Independent Development Council for People with Mental Handicap, London, 1986 (with IDC colleagues)

An Ordinary Life King's Fund Project Paper, No. 24, 1982 (with King's Fund Working Group)

CHAPTERS IN BOOKS

London's Health System: Autonomy and self-organisation in the swamp, in The Quest for Excellence: What is good health care? London, King's Fund, 1997

The Czech and Slovak Republics, in May, Annabelle (ed) Healthcare in Europe, London, Health Services Journal, 1993 (with Jan Jaros)

Users Leading Action in the Health and Social Services: Lessons from British Experience, in Pollo, M. (ed) L'Innovazione della cultura e dell 'intervento sociale nel mezzogiorno Rome, Labos, 1990

Achieving Strategic Change: A Principled Agenda for the 1990's, in Booth, T. (ed) Better Lives London, Community Care Monographs, 1990.

Changing Psychiatric Services in the Welfare State, in Ramon, S. And Gianichedda, M. (eds) Psychiatry in Transition London, Pluto, 1989 (with Su Kingsley)

Planning high quality local psychiatric services, in Lavender, T. and Holloway, F. (eds) Community Care in Practice: Developing Mental Health Services for the Continuing Care Client London, Wiley 1988

Towards a strategy for pursuing quality in the local NHS in Eskin, F. (ed) Creating Quality in the NHS Manchester, University Medical School Centre for Professional Development, 1987

Residential needs and services, in Craft, M., Bicknell, J. and Hollins, S (eds) Mental Handicap: A Multi-disciplinary Approach London, Balliere Tindall, 1985

Developing Better Services for the Mentally Ill: an exploration of learning and change in complex agency networks, in Barrett S, and Fudge C. (eds) Policy and Action London, Methuen, 1981

Moving out from the Institution: Strategies and Problems, in Alternatives to Mental Hospitals: Reports of a European Workshop London, IHF/MIND, 1980

PAPERS IN REFEREED JOURNALS

Promoting a better life for people with learning disabilities and their families: A practical agenda for the new government British Journal of Learning Disabilities Vol.25, No.3 pp90-94, 1997

Revaluing the NHS: Empowering ourselves to shape a health care system fit for the 21st Century Policy and Politics vol.24 no.3 pp287-297, 1996

Health and Social Services relationships in the reform of long term care British Journal of Social Work 15, pp 451-456, 1985

Policy Theory and Policy Practice: An encounter in the field of health service management development Policy and Politics Vol 13, No. 4 pp 431-445, 1985 (With Chris Ham)

Developing Mental Handicap Services in an English County: Lessons from an action research strategy. Hospital and Health Services Review January pp 9-13 and February pp 40-43, 1982

Developing effective management for the general nursing service Journal of Advanced Nursing 7, pp 309-317, 1982 (with Jenny Blake)

Towards professional autonomy: a commentary on 'Expectations and Disappointments' in development of the Royal College of Nursing Journal of Advanced Nursing 6 pp 497-501, 1981

Large Institutions Reconsidered: An approach to the management of transition Hospital and Health Services Review March pp 87-90, 1980

A 'social systems' approach to research and change in nursing care International Journal of Nursing Studies 16, pp 111-121, 1979

Large institutions: Problems and Solutions Hospital and Health Services Review October pp 359-365, 1978

ARTICLES IN POPULAR JOURNALS

Non-executives: Making a difference? Health Direct p12, January 1992

Travelling Light Health Services Journal Uncharted Territory (9 May, 1991 p21), Beauty and the Beast (13 June, 1991 p25), A Rocky Road To independence (15 August, 1991 p24), East or West, Unity is Best (3 October, 1991 p29), Over the Rainbow (12 December, 1991 pp30-31).

People First Community Care September 1991 pp 23-24 (with Virginia Beardshaw).

Values into Action: Sustaining the effectiveness of Canada's Community Living Movement Entourage Vol 6 No 3, Summer 1991 pp 5-6.

Old Values in New York Health Services Journal 5 April 1990 p520 (with Fidelma Winkler).

Common Goals Across Oceans Health Services Journal 4 January, 1990 pp 22-23 (with Derek Thomas).

Creating a shared vision Social Services Insight 13 September 1989 pp 20-22 (with Geoff Lake.)

Victorian Community Care Social Services Insight 30 August 1988 pp 20-21.

Learning the lessons of hospital closure Health and Social Services Journal 19 December 1985, p 1618

Waging war on the poor Health and Social Services Journal 10 October 1985 pp 1266-1267.

Managing psychiatric services, in transition Health and Social Services Journal 18 October 1984, Centre 8 (with Tom McAusland).

Dangers of patching up Health and Social Services Journal 21 June 1984 p826.

Una riforma in retromarcia Nautilus Supplemento al n 278, del Manifesto 1984.

Challenges in the Management of Long Term and Community Care

Health and Social Services Journal 31 July pp 921-922 (The Making of a Leader): 7 August pp 964-965 (Ending the Obstacle Race): 14 August pp 1000-1001 (Planning with People in Mind): 21 August pp 1026-1027 (Measures of Progress), 1981.

Alternatives to Mental Hospitals World Hospitals 16, 4 pp 17-19, 1980.

Developing services based on Large Institutions: Some organisational requirements Health Services Manpower Review 4, 2, pp 3-6, 1978.

OTHER PUBLICATIONS

Enabling People With Learning Disabilities To Lead Full Lives: Comparing national strategies for reform London, King's Fund, 1996 (Editor)

Partners and Pathways for Developing Primary Care London, King's Fund, 1995 (with Diane Plamping)

Developing the practice of collaborative commissioning: Supporting older people and their carers London, King's Fund, 1994 (with Richard Poxton).

Improving Health Through Locality Commissioning London, King's Fund, 1994 (with Richard Poxton).

Improving Respite Opportunities and Support for Adults with Learning Difficulties and their Carers in Bexley London, King's Fund College Working Paper, 1994.

Person Centred Planning: The implication for organisational development in the mixed economy of welfare London, King's Fund College Working Paper, 1993.

Value into Action: Strengthening CACL's Effectiveness in the Movement to Achieve Community Living, London, King's Fund College Working Paper, 1991.

Achieving Better Lives for People with Mental Handicaps in Czechoslovakia - Some suggestions from Western Experience London, King's Fund College Working Paper, 1991.

Foreword to Winkler, F. Who Protects the Consumer in Community Care? Lessons from North America London, Greater London Association of Community Health Councils, 1991.

Promises to Keep - Making community care for people with a mental handicap and their families into a reality in the 1990s London, NDT, 1990 (with NDT colleagues).

Proposals for the Independent Review of Services for People with Mental Handicap in Wales Cardiff, Welsh Office, 1989 (with AWS Panel colleagues).

Foreword to Australian Intellectual Disability Services - Experiments in Social Change (by Burton, M.) London, King's Fund College, 1989.

Inter-Agency Relationships in a National Strategy for Developing Community Care following the White Paper London, King's Fund, 1989 (with Gerald Wistow)

Foreword to Southwark Consortium 1984-1987: Organisation and Action in the Local Development of Services for People with Learning Difficulties (by Rochester, C.) London, King's Fund College, 1989.

Foreword to Staffed housing for people with mental handicaps (by Mansell, J.) Bristol, NHS Training Authority, 1988.

From small scale-developments to mainstream provision for people with learning disabilities: A framework for planning promotional initiatives in support of large-scale change. London, King's Fund College, 1988.

Foreword to Facing The Challenge London, King's Fund Project Paper No. 74, 1987.

Maintaining Momentum Towards High Quality Community-Based Services for People with Mental Handicap in the South West Bristol SWRHA, 1987 (Editor)

Foreword to Making the Break London, King Edward's Hospital Fund for London, 1986.

Achieving High Quality Community-Based Services for People with Learning Disabilities South Western Regional Health Authority, Bristol, 1986 (editor).

Foreword to The Limits of Altruism: Elderly mentally infirm people as a test case for collaboration (by Tim Dartington) King's Fund, 1986.

Foreword to The Employment of People with Mental Handicap King's Fund Project Paper No. 55, 1985.

Foreword to Training for Change King's Fund Report, 1985.

Introduction to Community Development in Health: Addressing the Confusions King's Fund Report, 1985.

Moving out from the Institutions, in Care in the Community - Keeping it Local London, MIND, 1984, 1984 (with Ann Davis).

Foreword to An Ordinary Working Life King's Fund Project Paper No. 50, 1984.

Preface to Learning to Relate? (Dennis Powell), London, Royal College of Nursing, 1982.

Foreword to Better Services for the Mentally Handicapped? King's Fund Project Paper, No. 34, 1982.

Inner City Community Services SAUS Working paper 15, University of Bristol, 1981 (with Chris Ham and Jackie Underwood).

Introduction to CHC Visiting King's Fund Project Paper, No. 23, 1979.