THE HEALTH ADVISORY SERVICE

an evaluation

Mary Henkel Maurice Kogan Tim Packwood
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King Edward's Hospital Fund for London

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CONTENTS

Tables

Figures

GLOSSARY OF ABBREVIATIONS

ACI	Assistant Chief Inspector (SSI)
BGS	British Geriatric Society
CHC	Community Health Council
DAS	Drug Advisory Service
DGM	District General Manager
DHA	District Health Authority
DHSS	Department of Health and Social Security
FPC	Family Practitioner Committee
HAS	Health Advisory Service of the National Health Service (Formerly Hospital Advisory Service)
ISHM	Institute of Health Service Managers
ISG	Information Steering Group of the Health Services Information Group
JCL	Joint Consultative Committee (between health and local authorities)
MAS	Management Advisory Service
MHAC	Mental Health Act Commission
NDT	National Development Team for People with Mental Handicap
NHS	National Health Service
PAC	Public Accounts Committee
RCN	Royal College of Nursing
RHA	Regional Health Authority
RLD	Research Liaison Division of the DHSS
SHAS	Scottish Hospital Advisory Service
SSD	Social Services Department
SSI	Social Services Inspectorate (Formerly Social Work Service)
SWS	Social Work Service
UGM	Unit General Manager
UMT	Unit Management Team
WO	Welsh Office

Introduction

The Health Advisory Service (HAS) has now been operating for almost exactly 20 years. This is the first detailed study of its effectiveness, and it is high time that such an analysis be published, for at least three reasons. First, the HAS aspires to be a major force in safeguarding standards of care for vulnerable groups of people, who suffer from long term illness and handicap: how well does it fulfil its role in this field? Second, its costs (£1 million per annum direct costs, plus some indirect costs incurred by health authorities and the Department of Health) are not wholly trivial: does it represent good value? Third, with moves being made towards more decentralised management – and (one hopes) towards closer coordination of a range of community-based services – there is a strong case for greater attention to standards: does the HAS offer a good model for agencies concerned with other aspects of health care?

Not surprisingly, the Brunel research team found these questions hard to answer. What they have done, with great care and competence, is to describe how the HAS works, and reflect upon what they saw and heard in their investigation, against the background of their own longstanding interest in this field. The result is valuable, both as a detailed record of the workings of an important public institution and as a stimulus to further thought about this and other similar agencies.

Let me then briefly give my own tentative answers to the three questions that I raised at the beginning of this Introduction, drawing on this study, without (I hope) implicating the research team in my interpretation of their evidence.

1 *How well then does the HAS fill its role?*

One standard evaluative approach is to accept role and objectives as they are defined by the organisation under scrutiny and see how well they are discharged. But this points up interesting tensions and ambiguities in the case of HAS, for its role has changed over time and has been perceived differently by different groups. It was seen by Richard Crossman, its founder, as the Minister's eyes and ears. That is not what it became, with a tenuous link to the Secretary of State and an accent on the promotion of good clinical practice (as defined by its visiting teams) and encouragement of local efforts to raise standards. This development agency role does

not always combine easily with an inspectorial strand, nor with a broader assessment of strategy. To write an objective, public report on the standards one finds in an institution or set of local services, is not at all the same thing as to act as confidante and trainer. Yet the HAS tries to do all these things. It also lacks (in my opinion) a sufficiently explicit range of standards to convince a sceptic that its judgments are correct.

This probably means the HAS can do even better than it has yet done, by clarifying the conceptual model underlying what it does, and by a stronger use of data of the kind that the Audit Commission has learned to deploy. (Indeed an alliance between the Audit Commission and the HAS must be worth exploring, now that the commission's role has been extended to include health.) Overall, however, what the HAS has done over the years is impressive. It has opened to informed observers the doors of what have sometimes (in all parts of the world) been depressed, neglected and even abuse-ridden institutions. It has encouraged interprofessional collaboration. It has drawn management attention pretty systematically to items that should be on its agenda.

Nobody should be complacent that abuses cannot happen, but they have happened less in the longstay institutions and allied services than before the HAS, and I do not believe that is coincidence. While this report seems to me to raise a number of quite sharp questions for the HAS, they are by no means of a kind to cast doubt on its past value. Indeed rather the reverse.

2 *Does it represent good value for money?*

While a direct cost of approximately £1 million (plus a variety of unquantified, indirect costs for others arising from HAS visits and reports) is a large sum, it is a modest enough national investment in standards in the longstay sector. That does not mean that its future value is permanently assured, or that the return on investment cannot be substantially increased, quite possibly with an *increase* in its costs. Again the Brunel team raises a number of questions about the functioning, scope and style of the HAS, which could increase its impact relative to its expenditure. But so long as it makes more than the most marginal contribution to standards in the field, we should not grudge its costs per se. It is more a matter of moving on from here.

3 *Does the HAS represent a good model for other development agencies in the NHS, for example some form of accreditation activity?*

The short answer, I think, is that there would be relevant lessons, but that no simple transfer of the HAS model would be appropriate. The range of expertise needed, for example to examine standards across the range of acute services, would be far wider and probably could not be assembled in the same manner as the current HAS teams. On the other hand, some important lessons can certainly be drawn from HAS experience, and from the findings of this research study. Thus, for example, the need for a clear, credible set of standards of quality would, I think, be inescapable. If an effective form of accreditation review is developed, then probably the HAS should be subsumed within it.

* * *

On behalf of the King's Fund, I welcome this report and thank Mary Henkel, Maurice Kogan and their colleagues for all that they have done to illuminate the workings of the HAS.

Robert J Maxwell
Secretary/Chief Executive
The King's Fund

1 The invitation

An evaluation of the Health Advisory Service (HAS), together with its Social Services Inspectorate (SSI) component, was first suggested by Robert Maxwell, Secretary to the King Edward's Hospital Fund for London, itself a powerful force supporting independent enquiry and development in the health service. The Fund undertook to find half of the funds for the study and, after some consideration by its research commissioning system, the DHSS* provided the rest.

To guide us in our study, a small steering committee was created consisting of representatives of the DHSS, the King's Fund, the HAS itself and SSI who would receive reports which might contribute towards the DHSS' thinking.

Throughout our work we were assured of the support and keen interest of the then Director and his colleagues at the HAS and the SSI. They hoped that the results of our review would be available to help inform any changes to be made.

We have had nothing but the most helpful collaboration from everybody involved in the study. The HAS opened all of its records to us. Field authorities gave us easy access to many busy people for interview and other forms of research. The members of the eight HAS teams whose visits formed our case studies were wholly co-operative, even when our study involved them working under the eyes of non- participant observers. We guaranteed that we should avoid particular references to any visit or authority but, nonetheless, their willingness to work under scrutiny involved considerable tolerance and courtesy at a time when they were having to work hard under considerable strain. We hope that our presence did not affect that work. Only in one of the studies was it reported that particularly stressful relationships between the visitors and the visited might have been accentuated by the knowledge that both were being observed.

The relevance of our study is multiple. It took place at a time when the tenure of the then Director, Dr. Peter Horrocks, was coming to an end and it was thought likely that the DHSS might decide to review the HAS' purposes and functions. So well documented an evaluative arm of a government department, which produces its own Annual Reports, as many as 40 reports of main visits, a similar number of reports of follow-up visits, and 12 reports of visits of the Drug Advisory

* Now the Department of Health. The earlier title is retained throughout, except where the context demands otherwise.

Service each year, should be a natural target for social scientists wishing to track the development of governmental and evaluative machinery against the changing political and social environments.

The policy issues are indeed important. More than ever public services are being evaluated. But are they being evaluated well?

What are the appropriate membership and expertise of an evaluative body? How far are teams selected mainly from the ranks of working professionals capable of evaluating objectively the quality of health and social services? What kind of evaluative techniques are appropriate to these two specialties, mental health and care of the elderly, in health and social service authorities in the 1980's? How far do HAS reports make an impact on practitioners, the providing authorities or the national policy system? How far does the HAS complement, or compete and overlap with, the many other bodies which evaluate health services? What kind of administrative structures and processes are needed to enhance its effectivenesss? What are its costs, and is it worth them?

A key issue is whether evaluation should be supportive, or critical, or both, and what it is in the case of the HAS. Can the evaluators simultaneously act as advisers to professional colleagues, and as inspectors or monitors or critics on behalf of the wider society? Advisers offer a service which can be accepted if thought helpful, or rejected if not. Inspectors make quality judgements against explicit and known standards which are used for purposes of control or management. They cannot be avoided by those receiving them.

Our evaluation leads us to be critical of certain aspects of the HAS. But that critique is primarily concerned with the ways in which a service which was conceived for particular purposes, and which did much good work in achieving them, can now be reorientated towards changed circumstances. HAS has greatly enlarged its scope and choices may now have to be made. In any event, we came away convinced that some such body as the HAS remained essential to the better working of the NHS and NHS-social services links and to the reassurance to patients, professionals and politicians that when all is not well, steps are taken to identify that which needs remedy. Our concern was to portray and analyse the evidence as we found it from our eight case studies and from work with some of the central bodies as objectively as we could and to contribute constructively to the debate about the HAS' future. We express great gratitude to all who have helped us in this quest although the majority of those who consented to our presence and investigations cannot be named.

Our approach

The aims of the study were to provide a summative evaluation of the workings and impacts of HAS in its visits to authorities and in the policy system at large; to engage in a limited formative evaluation with the HAS and DHSS; and to advance knowledge of the range and functioning of evaluative machinery in the health and social services.

To these ends we describe and evaluate the models of evaluation and of change that underpinned HAS work (Chapter 8); the methodologies employed to realise these models (Chapter 4); and the tangible outputs of teams in the form of verbal feedback and written reports to authorities (Chapter 4). We describe and analyse the encounters between the HAS, HAS teams and those visited (Chapter 4) and the actions in the authorities that followed the visits (Chapter 6).

Our approach to the evaluation of HAS was strongly conditioned by two factors. First, the HAS itself considers that the impact of a visit will continue to be felt over a long period. From the time of the inauguration of a visit to the time of the publication of the second follow-up, two years and a half after the main visit, an evaluation may occupy as long as three years. Moreover, one would expect such visits to have, if not enduring effects, then effects going well beyond the three year period of a particular visit.

Our evaluation had to be completed within a period of two years which was to include a substantial amount of time spent on identifying and gaining access to the districts and local authorities where we might undertake field studies and the period of writing up. It was thus impossible for us to take on board a complete HAS episode from its inception to the last of the follow up visits, some of which might take place four years after the first series of events. Instead, therefore, we undertook eight intensive case studies which between them allowed us to analyse and evaluate the working of HAS at different stages of the visit process. The first case study took place 20 months after the main HAS visit. The second case study took place four years after the original visit so that we might note the action taken by the authorities following the main and follow up visits. The third and fourth case studies were also retrospective: the third concerned an examination conducted by the HAS 18 months before and the fourth followed three years after the HAS visit. The fifth study was that of a current visit and involved the attendance of members of the evaluative team throughout the whole period of a visit and a follow up by the researchers to discern the reactions following the publication of the final report. The sixth study similarly

was a study of a current visit. The seventh and eighth case studies were of follow up visits, both of which were attended.

Second, in selecting our cases we divided the eight between visits of services for the mentally ill and for the elderly. Each of the case studies was written up in full and made available to members of our Steering Committee. These constitute the main data upon which this report is written. They are not publicly available because it would be difficult to protect the anonymity which we undertook to sustain. We also interviewed members of other relevant evaluative bodies and the main professional associations concerned with services for the mentally ill and elderly. We conducted meetings and interviews with members of HAS staff. In all, we conducted 272 interviews for the case studies and 28 interviews and meetings with national bodies, including the DHSS and the Scottish HAS.

Members of HAS staff had hoped that our study would be formative. That indeed was and remains our intention for we hope that our findings will contribute towards thinking about the future working of the HAS both within the service itself, and in the DHSS and the Social Services Inspectorate. In the event, however, a full formative study could not be achieved. That would have involved far more recurrent feeding back to HAS with a view to helping them clarify beneficial changes which we would then reiteratively assess. Neither our resources generally nor our time frame made such a relationship possible. In other ways, however, the relationship with those being evaluated had been interactive and this is largely due to the open, friendly and self-critical way in which Dr. Peter Horrocks, Mr. Brian Wiggins and, more recently, Professor Philip Seager have met us and opened up their files for whatever use we have thought appropriate.

Our approach has been less than formative in another way. Formative evaluation involves taking the objectives of those being evaluated as the datum line upon which an evaluation will be based. Quite soon, however, we realised that we could not take for granted the stated objectives of HAS which are to be not inspectorial but advisory, and based on a colleague and peer review style and purpose. One of our early findings was that many in the field regarded HAS as strongly inspectorial. It was in any case important to reserve judgement on whether services needed evaluation which would be advisory or inspectorial or both. We were invited to make evaluations of HAS' effectiveness although, as will be seen from Chapter 6, where we attempt to assess the impact of HAS, such an evaluation is difficult to make.

2 The context

History and policy contexts

The development of HAS

The role and functions of HAS were ambiguous from the beginning. Its creation as the Hospital Advisory Service in November 1969, to monitor and improve the quality of care received by the elderly, mentally handicapped and mentally ill in long stay hospitals, responded to a recommendation for an inspectorate in the report of a committee of enquiry, chaired by Sir Geoffrey Howe, into conditions at Ely Hospital for the mentally ill and handicapped (Howe, 1969). An inspectorate would be one means of counteracting the failure of service management either to monitor sufficiently the quality of care within long stay institutions or to take rigorous action to rectify shortcomings. This idea was seized upon with alacrity by Richard Crossman, the Secretary of State for Social Services. He saw an inspectorate, first, as a means of enabling him, personally, to monitor standards of care; a bizarre ambition for a busy minister. Such an augmentation of, or perhaps alternative to , the efforts of his own Ministry officials would help prevent the emergence of more politically damaging revelations of institutional life. Further, an inspectorate for the chronically ill within long stay institutions would actually create political capital, in that it would provide a measure of positive discrimination for the most deprived. Finally, in the immediate term, its creation would disarm political criticism resulting from Ely. The government would be seen to have acted.

Initially, then, HAS can be seen as a testimony to a minister's scepticism about both the management of his own service and the diligence of his officials in keeping him informed. Not surprisingly, DHSS officers had reservations regarding the innovation. Crossman's diaries reveal the disputed ground.

> 'I was quite prepared to give up the main inspectorate and have a scrutiny or advisory service but the key to it in my mind is that it should be an organisation completely separate from the policy making and administrative set up in the Ministry. It should be an independent group of people inspecting and reporting to me'. (Monday 17 March 1969, Crossman, 1977).

So from the outset there was resistance to the hard evaluative image associated with an inspectorate and pressure to adopt the softer

persuasive approach encompassed by the term 'advisory'. An inspectorate was interpreted as not just 'the eyes and ears' of the Minister, as Crossman wanted, but also as 'an arm'. There was a concern from within the NHS that, whatever body was set up, it should be kept independent of existing authorities, local or national. By the end of March Crossman himself was referring to the new body as a policy advisory service, although he, at least, was clear that it was *his* policy advisory service and continued to use the terminology of 'inspectorate' and 'advisory body' interchangeably.

Under the first Director, Dr. Alex Baker, the advisory model became dominant and it also became clear that the advice would be for professionals working in the service, as much as for ministers. HAS developed as a body seeking change through persuasion and education, an in-house pressure group that sought to raise standards across the service (Day, Klein and Tipping, 1988). The initial terms of reference illustrate the twin concerns:

(i) By constructive criticism and by propagating good practices and new ideas, to help improve the management of patient care in individual hospitals (excluding matters of individual clinical judgement) and in the hospital service as a whole; and
(ii) to advise the Secretary of State for Social Services about conditions in hospitals in England and the Secretary of State for Wales about conditions in hospitals in Wales (Watkin, 1978).

The focus on local service practice became even clearer in 1976, when the functions of HAS were reformulated. First, community services, including those provided by local authority social service departments and voluntary bodies, were added to the remit. The name was changed accordingly from Hospital to Health Advisory Service and it began to work in partnership with the DHSS Social Work Service, itself later to be recommissioned as the Social Services Inspectorate. At the same time, responsibility for advising on mental handicap services in England, although confusingly not in Wales, was transferred to the newly created National Development Team for People with Mental Handicap (NDT).

The functions of the new model HAS were defined as:

(a) 'encouraging and disseminating good practice, new ideas and constructive attitudes and relationships; and
(b) acting as a catalyst to stimulate local solutions to local problems'. (DHSS/WO, 1977).

Martin (1984), in his lucid account of the development of HAS, suggests that the reformulation of the functions of HAS in 1976

marked a reduction in direct ministerial interest. Certainly reports made to ministers became less formal. Clearly, too, the change marked the growing importance of community care as a policy issue, already recognised in HAS practice. The new mandate meant that the service could incorporate social services facilities in its work by right.

By 1979, the Royal Commission on the NHS was clear that HAS was operating as an advisory services that functioned:

> 'by persuasion rather than coercion'.

The Commission explicitly resisted the proposal that HAS should have its functions strengthened and converted into an inspectorate (Royal Commission, 1979). The government was not, as it turned out, so sure that an inspectorate was not required in the NHS. When considering the reorganisation of the service in 1979 the DHSS suggested that:

> 'on an experimental basis in one or two regions, responsibility for monitoring the quality and efficiency of the ways in which health services are managed, and for advising on the development of services at district level, might be discharged not by the RHA but by an advisory group of experienced NHS officers'. (DHSS/WO, 1979)

This proposal eventually led to Management Advisory Service trials which we have reported elsewhere (Brunel, 1984). The existence of these trials, although they, too, were characterised by ambiguous expectations from central government, suggested that central government saw the need for a form of evaluation that was not apparently being satisfied by HAS.

The focus of the HAS had clearly changed since 1969. Early reports testify to a (well justified) priority with the detail of service provision. Nearly 20 years later this is still an ingredient, although the need for urgent action, if still there, has generally lessened, but reports are more concerned with the broader detail of service policy, planning and management.

Throughout its life HAS has been responsive to emerging policy concerns. Community care, mentioned above, is the obvious example, but in 1986, the Drug Advisory Service was created under the auspices of the HAS to monitor and help promote services for problem drug users.

As HAS has receded to some extent from the sight and hearing of ministers, so it has been encouraged to gain greater public support and to enlist the help of the media in securing attention for its recommendations. Reports have been published since 1985. This,

too, suggests a move away from the 'in-house', discreet, professional educative approach, towards a wider promulgation that recognises public interest and power. The HAS has produced influential reports condensing its experience on specific subjects. *The Rising Tide* was a manual of guidance on the provision of services for elderly people with mental illness. (NHS HAS, 1983) *Bridges Over Troubled Waters* was concerned with the provision of services to disturbed adolescents (NHS HAS, 1985).

HAS now has its fifth Director. Directors serve for three to five years. To date they have all been doctors, drawn alternately from a background in psychiatry and geriatric medicine. The personality of the Director is important both in setting the direction and style for HAS working. Day and her colleagues point out the change of emphasis when Dr. Woodford-Williams succeeded Dr. Baker (Day, Klein and Tipping, 1988), and provided HAS with its public persona. Crossman's diaries, to return to our starting point, highlight the time and trouble required to secure a suitable appointment (Crossman, 1977).

The history of the HAS demonstrates how able and energetic individuals, politicians and Directors, can shape the nature of the service. Even more, it shows how social institutions reflect their broader social and economic context.

The years from 1969 until the late 1970's could be characterised as the era of structural reorganisation and consensus management. Health service policy was, as Eyles and Klein have analysed (Eyles, 1987, Klein, 1983), marked by a belief in rational planning; in the possibility of creating organisations to serve particular collective ends. At the same time, there was also a belief in the value of expertise, and in trusting professionals to serve the public interest. The initial creation of the Hospital Advisory Service can be seen as an illustration of the belief in rational intervention and the way in which it quickly came to operate as a source of persuasion is congruent with the trust in professionals.

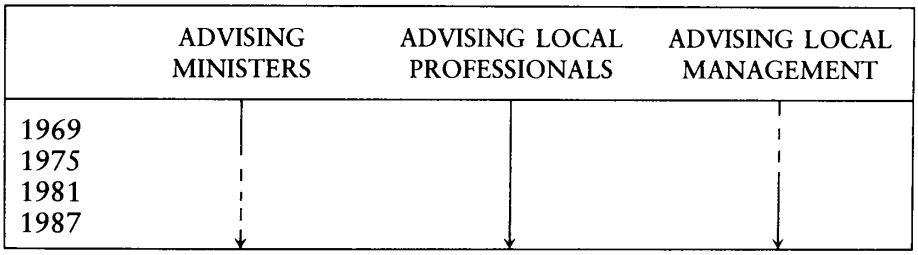
By the late 1970s the context for all the social services had changed. Social engineering was distrusted, as was the expert. Public services were required to be returned to the private market. If they had to be retained they required strong management, with an emphasis on efficiency and hard, objective measures of performance. At the same time, however, the interests of individual consumers required more attention.

The earlier discussion suggested that HAS has bent to new winds in the course of its history, but the question remains whether, and in what form, HAS is needed in an era of general management and

performance indicators. Management and its capacity to monitor the service are more efficient today. Some believe that there is less fear of the failures in standards of care that gave rise to HAS occurring in the future. Although it is widely felt that such scrutiny is still needed, it does not follow that Ministers must have their own inspectorate. Management might exercise quality control directly with the professionals, without the need for a third, and external party.

The major changes in focus over the lifetime of HAS are summarised in the diagram below.

Figure 1 Changing role of HAS



The service context

Our case studies concerned HAS visits from 1982 to 1988, a period during which services for the mentally ill and the elderly were a priority for both health and social services but not the only ones. They form part of a complex agenda involving many different governmental and political entities.

Within this complexity of priority setting, the HAS has to take into account the policy emphases of promoting efficiency and seeking value for money (Eyles, 1987). So far this has had a muted impact on health services for the elderly and mentally ill. Attention has been concentrated on the main line acute services, although current resource management experiments include community services. A second relevant policy emphasis is that on community care although it is now realised that this has gone wrong, both financially and organisationally (Audit Commission, 1986, Griffiths, 1988). If it is recast as recently recommended by Sir Roy Griffiths, social service responsibilities would become more central and the role of HAS as primarily a health advisory service might then require adjustment.

Other contextual factors affect the work of the HAS. Both health and social services are highly professionalised and HAS must therefore relate its recommendations to the patterns of organisation and decision making that result. At the same time, there are pressures

towards stronger accountability and social services have, indeed, always had a strong hierarchical organisation. In the health services, too, the Griffiths proposals (1983) introduced a general management function which, together with the stress on efficiency and value for money, has increased the authority of service managers as against those of professionals. The institution of general managers brought significant changes and was a major pre-occupation of some of our study districts at the time of the HAS visit. The combination of strong professionalism and of increased management authority again makes a complex setting within which HAS does its work.

Finally, both health and social services are political organisations and HAS recommendations involve political choices. The power of some professionals within the health service in particular is well attested yet policies must be sanctioned by local councillors and members of health authorities. These individuals who may have their own priorities formally receive the HAS advice and could be more involved if they wish. But in our eight case studies they were marginal to the HAS process.

The stated purposes and perceived nature of the HAS

DHSS Circular HC(84)16 states HAS' purposes which are reproduced in the *HAS Memorandum for Team Members* which guides their work in the field. The Memorandum contains explicit statements of purposes as follows: 'The NHS Health Advisory Service

- exists to maintain and improve the standards of management and organisation of patient care services, mainly those for the elderly and mentally ill.
- is independent of the Department of Health and Social Security and the Welsh Office.
- is free to comment on all aspects of organisation of the NHS.
- does not investigate individual complaints nor matters of individual clinical judgement.
- reports through its Director to the Secretary of State for Social Services and the Secretary of State for Wales and the Authorities concerned.
- in collaboration with the Social Services Inspectorate of the DHSS and Social Work Service of the Welsh Office (for convenience, referred to as the Social Services Inspectorate (SSI) in this memorandum) promotes effective co-operation between health and local authority services.'

It goes on to say that:

'The purpose of the health advisory service/social services inspectorate visit and report is:
- to look at existing services for the client group concerned.
- to provide an objective assessment of those services.
- to advise those concerned on how to build constructively on what they have, by concentration on
  - methods of management and patient care organisation.
  - interdisciplinary collaboration.
  - education and training of all grades of staff.
  - co-operation between agencies, especially in planning.
  - mobilisation of the necessary resources.'

It adds that

'In addition to its responsibility for visits and reports on individual services, the HAS is also able to
- keep Government aware of the outcome of a service provision for the client groups concerned.
- identify good practices which can be generally disseminated.
- identify areas of difficulty in the provision of services, especially those which may require policy changes.
- issue guidance for the use of health and local authorities in the form of 'manuals of good practice'.
- issue an Annual Report'.

These terms of reference are consistent with the trend away from an inspectorate described above. The point is reinforced in the Preface to each of the HAS reports to the Health and Social Service Authorities visited which states: 'Team members do not approach visits in an "inspectorial fashion". In contrast they bring their own experience of similar working situations in a form of peer review'. In his last Annual Report as Director, Dr. Peter Horrocks (Annual Report, June 1987) stated that the teams provided an objective, professionally based review of district services and proffered advice which is unique both to the team members and to the local circumstances that they find. The effect is to help each particular service, whether its current status is poor or whether it is achieving highly already. Dr. Horrocks believed that the findings of the HAS teams prove to be largely complementary to information derived from performance indicators, giving much clearer indications of quality and effectiveness than numerical data.

In his view, the individual nature of each visit was both a strength and a weakness. For each team to reach its own conclusions meant

that its advice would generally reflect the best current professional perceptions and would be locally applicable. Teams would not be so effective if they were simply following a nationally agreed detailed check list of desirable characteristics.

To meet what might be a weakness and what the Director described as 'undoubtedly a growing demand for definitive statements of the necessary components and functions which each district should be providing for elderly and mentally ill people' the HAS condensed its experience into guidance documents such as *The Rising Tide* and *Bridges Over Troubled Waters.* (HAS, 1983 and 1985) But overridingly the HAS' self-perception was that of a non-authoritative, interactive peer review system reacting to the uniqueness of what it found in the field rather than assessing the standards of what was seen against pre-determined criteria.

HAS and the range of evaluative bodies

A large number of institutions evaluate the NHS for different purposes and the HAS might be compared with them. Professional bodies, such as the nursing boards, the Royal Colleges of Psychiatrists, Physicians and General Practitioners, evaluate services to ensure that they are a suitable site for professional training. Some also provide a peer review system to enhance professional standards. The HAS, however, can also be compared with those institutions which are concerned with more general purposes of accountability and which have some formal status derived from their creation by the DHSS. There are the arrangements for monitoring outlined in the 1972 Grey Book; there is the formal planning system established from 1974; the regional reviews first noted in the Seventeenth Report of the Public Accounts Committee 1980/81; and there are complaints procedures derived from those proposed by the Davies Committee (1975). There are also a number of more specific evaluating bodies and these are considered below.

NATIONAL DEVELOPMENT TEAM FOR PEOPLE WITH A MENTAL HANDICAP (NDT)

As far as external evaluation is concerned, a neighbouring body with a similar remit to the HAS is the National Development Team for People with a Mental Handicap (NDT) for England which was set up in 1976. Its creation followed the concern of the then Secretary of State, Barbara Castle, that the implementation of the 1971 White Paper, 'Better Services for the Mentally Handicapped' was not taking

place as planned. The terms of reference of the Team, as reaffirmed by Ministers in 1987, are to:

- advise health authorities and local authority social services departments on the development of services for people with a mental handicap
- disseminate information and ideas about good practice and good strategies;
- act as an additional source of information and advice to Ministers and the Department.

The NDT has always emphasised that it visits by invitation only, although the Secretary of State has the residual right to ask for a visit to be made. Also, it has always emphasised the importance of local authority social services departments in the development of services for people with a mental handicap.

Following a review of NDT strategy in 1987/88, the incoming Director decided that the elements of a new strategy should be developed. This emphasised the intention to provide more flexible services to field authorities, and it also recognised that services were at different stages of development in different places. The NDT adopted a more proactive role focusing on issues which had urgent national significance. It undertakes sequences of related work and seeks to cluster visits in a few regions at a time in order to increase its understanding, influence and impact on a regional strategy, as well as its own sequential learning. It was also important for the Team to make explicit its values and principles. In particular, the issue of quality was felt to be best addressed by looking at the experiences and wishes of the users of the services, people with a mental handicap, and also by taking into account the views of their parents and relatives.

There are three part-time Associate Directors. The multi-disciplinary teams, which are drawn from NHS and local authority practitioners who act as consultants for particular visits, normally include a parent of a mentally handicapped person. Until 1987 there were normally 10 to 12 visits a year lasting from one to three weeks by teams of up to 12 members. Under the new strategy it remains essentially a Team consultancy that is offered, but there is a wider variety of visits. The terms of reference are agreed with the authorities concerned, and visits may have very different purposes:

- short term problem-solving/arbitration
- short term 'one-off' consultancy regarding plans and proposals
- more general external review/advice on service objectives,

service models, organisational arrangements and implementation strategies
- more detailed programme evaluation
- assistance with new forms of service design work
- advice on internal monitoring and review systems
- follow-up advice or linkage into other consultancy or training networks.

Team sizes and the length of visits tend to be less than in the past, reflecting the increase in short-term briefs.

The Team is experimenting in ways of presenting its findings, including local feedback meetings involving representatives of the families of people with a mental handicap and voluntary organisations. There have also been recent experiments in which the host authorities, rather than the NDT, agree to produce a report, or contribute their proposed action for inclusion in the NDT's report. In 1988 the NDT began to issue national press releases highlighting the matters of national interest in its published local reports, and encouraged its host authorities to issue local press releases. The authorities are encouraged to 'own' the reports' recommendations, and it is up to them to decide on implementation. They are not obliged to submit a progress report or to receive a follow up visit, but the NDT is willing to help if so desired, either by direct involvement or suggesting other sources of the specific skills required.

The NDT is not part of either the NHS or DoH although it is accountable to the Secretary of State. It is, however, closer to the DoH than is the HAS. It is sponsored directly by a Departmental Branch and has its base in the same building.

The NDT can be said to be similar to the HAS in terms of its stated functions, but it has in the last two years become more explicitly a developmental and consultancy agency with the emphasis on a formative approach.

HEALTH SERVICES INFORMATION GROUP

Of entirely different genre is the English Health Services Information Group and its Steering Group (ISG) which has met under the chairmanship of Dr. Körner. It is concerned with reviewing NHS management information systems and ensuring that they are designed to meet the needs of operational management and planning rather than the views of central government. It is generally concerned with the quality and content of data and their effective use.

The Committee set up a sub-committee which would design a minimum basic data set for each authority. These were developed in

consultation with data providers and data users. The Committee is responsible not only for recommending data systems but also for overseeing their implementation. It has vigorously promoted the training of data collectors in the NHS and sees this, together with the introduction of appropriate information technology, as the key to implementation.

Whilst the Körner Committee operation has depended upon collaborative work with professionals in the field, their intention is to ensure the creation of 'objective' data for use rather than the assessment of professionals by professionals as is the HAS mode.

MENTAL HEALTH ACT COMMISSION (MHAC)

In the course of our evaluation, staff in the authorities sometimes mentioned comparisons between HAS and the Mental Health Act Commission which started work in 1983.

It is a special health authority consisting of a Chairman and 92 other members who are drawn from different professional backgrounds, including some from outside health and social services. There are also a number of lay members. All have particular interests and knowledge in one or more fields of mental health. They are appointed by the Secretary of State initially for a period of two or more years and work part time. The average has been more than two days service a week. The Commission is divided into three geographical regions with, at its centre, the central policy committee consisting of a Chairman, ten Commissioners appointed by the Secretary of State and six co-opted members. It meets at least monthly.

The Commission began with no existing pattern for performance of its tasks and developed a framework empirically as it gathered collective experience. Each region has a degree of autonomy to ensure that regional differences can be assessed through local knowledge of the appropriate region. Autonomy also enabled variation in fulfilling functions which could be treated experimentally.

The full Commission meets half yearly so that different experiences can be shared and decisions affecting general policies taken. In effect, the commission is a large multi-disciplinary organisation operating through smaller teams of a similar multi-disciplinary nature.

The MHAC is thus very different in its resources and working modes from the HAS. Yet some in the field believe there to be a blurring of role. Although the Commission's main focus is the treatment of individuals it inevitably evaluates the services they receive. It carries more explicit and legal authority than does the

HAS, reinforced by the fact that the Chairman is a lawyer. However, although it possesses greater authority because of its legal function, its evaluative span is narrower than that of the HAS as is demonstrated by the fact that MHAC visits last one day only compared with the three weeks or so of the HAS visits.

The MHAC's functions are specific because they are intended to protect the interests of detained patients whom they visit and interview. Commissioners may investigate complaints by and about detained patients and keep under review the way in which powers and duties under the Act are carried out. They can arrange for the provision of second opinions by appointed doctors and carry out reviews of treatments. They also draft a code of practice. This sharpness of focus derives partly from the fact that they are concerned only with the relatively small number (about 6,500) of patients compulsorily detained under the 1983 Act. The Commission also extends its field to the position of informal patients although this is thought by some to be going beyond its remit. In its visits to social service departments, the Commission concentrates principally on the adequacy of communication and collaborative work between health and local authorities. This again overlaps with the HAS.

THE SCOTTISH HOSPITAL ADVISORY SERVICE (SHAS)

The Scottish HAS (SHAS) was established in 1970. Its terms of reference are both more limited and sharper than those of its English and Welsh counterpart. It is 'to provide objective advice to the responsible authorities about the standard of care provided by them ... and to make recommendations to the Secretary of State and Health Boards as it considers appropriate'. (SHHD, 1981). It is to advise on the management and requirements of different parts of the service. It acts for the Scottish Health Service as an information centre. It is 'to help in the future planning of facilities and services for patients in such hospitals' and 'to advise on research, education and training needs'. It is to provide opportunities for staff to meet and discuss relevant matters with SHAS through visits or through conferences and seminars arranged by the SHAS.

In contrast to the HAS the SHAS is specifically a *hospital* advisory service, concerned with institutional services rather than the complexity of community provision. It does not assess the work of social work departments except for the service they provide to hospitals.

The SHAS is also structurally different from the HAS because it forms a division of the Common Services Agency. It has a far larger central core. There is a Director, a Medical Officer, two Nursing

Advisers, an Administrative Secretary as well as other staff. Two Social Work Advisers work part time.

The Scottish HAS draws upon a pool of practitioners to make up its team. One of its own permanent officials is always a member of the visiting team. It also engages vigorously in follow up visits in which it sets out to help authorities meet its recommendations.

We have not had an opportunity to evaluate how the SHAS works but we understand that it sees itself as actively helping authorities and social work departments to improve what they provide, and that with that intention it takes on virtually an organisational development role with some authorities. This would move the service both from an advisory role (promoting a service which may be rejected) and from an inspectorate (forming judgements upon which others are expected to act).

SOCIAL SERVICES INSPECTORATE

The Social Services Inspectorate, despite its name, continues to be pulled between its inspectorial and advisory functions, although the history of those pulls has a different pattern from that of HAS. Unlike the HAS it is part of central government.

Two departments of central government had responsibilities for the personal social services that were amalgamated into social services departments in 1971: the Home Office and the Ministry of Health. They represented two traditions in the relationship between central and local government. The Home Office through its inspectorates has been described as regulatory and the Ministry of Health laissez-faire (Cooper, 1983), although the position was in fact more complicated.

The Children's Inspectorate combined regulation with advice to local authorities and gave them considerable latitude in policy development.

1971 saw the creation of the Social Work Service (SWS) in the DHSS. The concept of an inspectorate was eschewed, except that some of the laws governing the personal social services carried inspectorial powers which were transferred to the SWS. The main functions of SWS were spelt out in 1971: to contribute to policy development in the DHSS; to act as a regional point of contact between DHSS and local authorities on the personal social services; to support, advise and inform local authorities and voluntary organisations on personal social services matters and to exercise regulative power on behalf of the Secretary of State.

By 1977 pressure was building up in some quarters for a more extensive inspectorial role for SWS but its head resisted this and

reasserted its professional and advisory mandate. 'What sanction is there in the last resort to compel good standards and good quality? In the end, one must depend on persuasion, influence and motivation to achieve them'. (Utting, 1978).

The Barclay committee on the role and tasks of social workers reiterated (1982) the call for an inspectorate for the personal social services: the majority were for an independent inspectorate and the minority for extended inspectorial powers for the SWS.

In 1985, the SWS was finally converted into the Social Services Inspectorate (SSI) with a mandate to pursue value for money as well as good practice and it was explicitly to encompass social services in its remit, as well as social work. But the professional advisory and supportive functions have continued to be strongly endorsed, particularly in the SSI regions. At the same time there is more emphasis at the centre on inspection and the setting of national standards, and on giving the work a more authoritative social science base.

At the end of a period of complicated evolution, the HAS can be compared with other evaluative bodies on the following dimensions. It is focussed on specific client groups, as are the NDT and the Mental Health Act Commissioners. It reports to but is autonomous from the Secretary of State for Health as is the NDT. Its mandate is advisory but it also evinces an inspectorial and monitoring capability and style. It is concerned with both the NHS and social services department provision, in contrast to the Scottish HAS. It focusses on services for client groups rather than individuals, in contrast to the Mental Health Act Commissioners.

3 Our methods and perspectives

Our study was to be the first major evaluation of the HAS since its inception in 1969, although a parallel study has been undertaken at Bath University (Day, Klein and Tipping, 1988). We have seen that by 1986 both the functions of HAS and the context in which it worked had undergone major change. Our study was thus concerned with an evolving institution at work in an environment of upheaval.

The main focus of our study was on the visits of HAS teams and their impacts in the authorities. An important component of our task was to describe and analyse how HAS worked. We were aware of the limitations of evaluative studies that identify outcome without relating it to input or process. (Sinclair and Clarke, 1983).

There are few constants in HAS. As we have noted, it has a new Director every three to five years, who runs the service with the help of a very small administrative staff; there is now no core team membership, although there used to be; each HAS visit has an individually selected team and the pool from which team members are chosen has a continual inflow and outflow. Thus the relationship between the HAS teams and the HAS directorate emerged as an important element in our study.

The HAS worked on a concept of change which emphasised process and movement among those they evaluate. They do not assume a simple linear relationship between the stimulus of an evaluative visit and the responses made by the NHS. Their concept of change is that of a catalyst (HAS was to stimulate local solutions to local problems) and of 'normative re-education' (Bennis, Benne and Chinn, 1969) (HAS was to encourage and disseminate good practice). Although the requirement of HAS to report direct to the Secretary of State incorporates a notion of coercive change, its importance, as we have seen, has diminished. The main sources of action are to be the authorities visited.

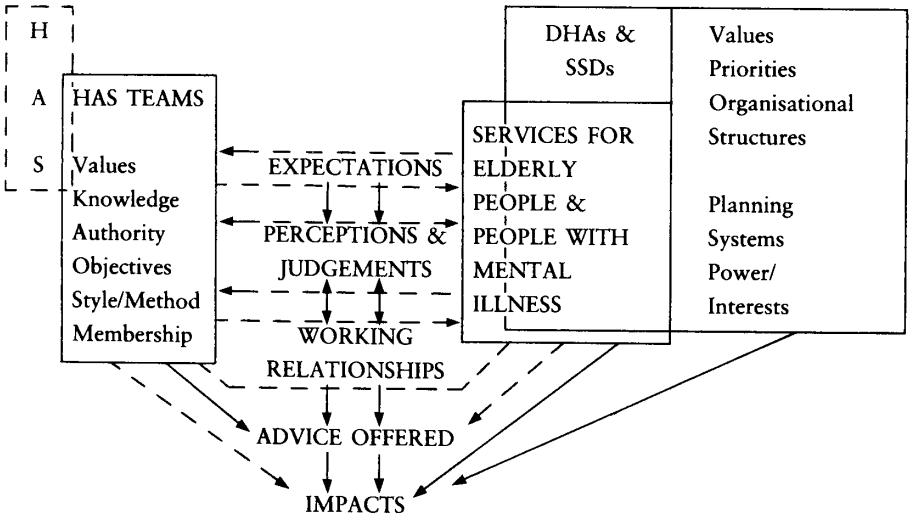
The subject of our evaluation is not a simple system or programme with underlying fixed objectives. The demands upon HAS teams are both cognitive and expressive. They are required to make 'objective assessments' of services but also to engage with, stimulate and encourage staff.

HAS has multiple sites of action and multiple groups of actors. The objectives of the service place a premium on interaction and

individualised outcomes. Individual, group and organisational interpretation is essential to its working. Impacts are expected to be a product of the relationship between teams and those visited. All these factors make it probable that changes attributable to HAS will emerge over quite long periods of time.

These assumptions led us to a tentative model for our research in which impact is to some extent embedded in process. A simple representation of it is seen in Figure 2.

Figure 2 HAS – Authority relationships



The model illustrates how HAS outputs and impacts are the product of interaction between the HAS team and the authorities, their mutual perceptions and expectations. Relationships between team members and those in the authorities visited are seen as key outputs, along with the judgements reached in the team and the advice developed from them. Impact is a function of all of these factors.

The model required the research team to focus as much on those visited as on the HAS itself if impact was to be understood. We hypothesised that impact would depend on the perceptions in the field of the authority of HAS, of the salience of its advice, of the resource implications of the team's advice and of the pressure of competing demands; but also on planning capacities, policy implementation structures and norms, and interest group alliances and power in the organisations visited. Impact would depend on the politics of the local scene: the internal politics of the health authority and the relationships between health and local authority, the

voluntary organisations and patient or consumer interest groups, although we did not identify the complexities of this system at this stage.

Equally, the HAS was part of the wider politics of the NHS. Perceptions of the HAS in the larger policy system, its location amongst other evaluative mechanisms and its impacts in professional communities and amongst decision makers in central government were likely directly to influence perceptions of the authority and the salience of HAS advice amongst those visited. We adumbrated a process model of HAS that took into account the various potential targets of HAS and its various modes and relationships with policy makers. We did not, however, directly address the influence that other forms of evaluation and control might have on HAS. Thus the interconnections between the different parts of the project were not at the outset fully taken into account.

Methods

The complexity of our inquiry ruled out an experimental approach to evaluation. In particular, an approach that divorced the phenomenon under investigation from its context would have been quite inappropriate. A systems analysis based on assumptions of fixed objectives, itemised programmes of action and the measurement of outcomes by key performance indicators would have been equally unsuitable. It might theoretically have been feasible to select a number of performance indicators of services for the elderly and the mentally ill and to look at authorities on these dimensions before and after HAS visits. But even if such indicators were well developed, they could only enable us to record achieved change. Use of them would not address the question whether those changes could be linked to the intervention of HAS nor could any method based on a simple cause-effect model of impact. We did, however, use a form of the time series approach advocated by Cope (1981) for the study of organisational change. In this approach, the site of action or change is visited at specific intervals before and after an intervention to identify what change is occurring and the direction in which it is moving.

Case studies seemed most likely to yield data through which we could analyse the working of the HAS and its impacts. Case studies, as defined by Yin (1984), have a number of characteristics relevant to our inquiry. They investigate 'a contemporary phenomenon within its real life context; when the boundaries between phenomenon and

context are not clearly evident; and (they use) multiple sources of evidence'. Yin also outlines their particular roles in evaluative research. They may enable researchers to explain the causal links in real life interventions that are too complex for survey or experimental strategies; to describe the context in which interventions occur; to illuminate the interventions themselves; and to explore situations in which the intervention being evaluated has no identifiable, single set of outcomes.

Case studies

Within the frame of the case study, we concentrated on the mainstream of HAS activities: the visits of teams to authorities to advise on the management and organisation of services for elderly people and people with mental illness. We selected eight examples, as outlined in Chapter 1.

The principles behind the selection of the eight case study visits were that, within the time available to us, we should observe as much as possible of the work of the HAS at first hand and that we should consider the impact of the visits over as long a period as possible. We thus directly observed four visits, two main visits and two follow up visits. (Follow-ups take place approximately two and a half years after the main visit and are designed to check with authorities the progress made in the intervening period.) In addition we made a retrospective study of four visits that had taken place at various times up to four years before our project began. The NHS reorganisation of 1982 was our cut off point.

The whole schedule of visits from 1982 onwards was made available to us. From it we selected some visits identified by the Director as either routine or as producing problems; we then made further selections of our own. We took into account the following characteristics or factors: metropolitan inner city, suburban and rural location; geographical distribution (our study was confined to England); coterminosity; RAWP losers and gainers. We included one visit made at the invitation of the health authority; the other visits were programmed in the normal rolling HAS schedule.

The distribution of types of study and the main factors taken into account are tabulated on opposite page.

Two of the visits were in the North of England, two in the East and four in the South.

We used three main sources of evidence. First, we studied documents. HAS made all of their data available to us. We

Table 1 Selection of case studies

	Observed/ Main	Observed/ Follow-Up	Retrospective/ Main
Elderly	1	1	2
Mental Illness	1	1	2
Coterminous	1	1	2
Non-Coterminous	1	1	2
Resource Gainer	1	1	1
Resource Loser	–	1	2
Resource N*	1	–	1
Inner City	–	2	1
Suburban/Rural	2	–	3

* Neither gainer nor loser under RAWP

concentrated mainly on the files of the authorities to which our case study visits were made, including correspondence conducted with HAS six months after visits, but also examined HAS' index of good practice, its memoranda of guidance to HAS team members, its annual reports and its special studies. The authorities were similarly generous. Records of meetings, reports, strategy documents and other evaluations of services were made available to us. They provided invaluable evidence of the HAS process, its implications and outcomes, of the context of HAS work and of other events and interventions that influenced the responses and actions in the authorities.

Secondly, we directly observed four visits. We attended most of the meetings between the HAS teams and those visited in the course of these events and a number of the teams' own private meetings. We were there in a strictly observer role and took full notes of what we saw and heard. We attempted to note the content and particular emphases of the meetings, their structure and setting, who attended, the modes of inquiry and response adopted by the team, the modes of presentation and response of the individuals and groups seen and patterns of interaction and influence within the team and between the team and those whom they met.

Third, we carried out semi-structured interviews with a range of people concerned with the visits comprising all our case studies: staff at HAS headquarters; HAS team members; staff in the case study district and regional health authorities; staff in the local authority social services departments; members of health and local authorities; members of voluntary organisations, Community Health Councils and trade unions. On the basis of these interviews we could gain

multiple perceptions of the processes, outputs and outcomes of the visits and an insight into the thinking, aspirations and actions of those involved.

We asked respondents about the purposes of HAS visits, their expectations of them and the preparation they made for them. We elicited views about the programme of visits, the encounters between team members and those visited, the attitudes of participants and the understanding, methodologies and evidence that formed the bases of the judgements they reached.

We sought the perceptions of team members and of those visited of the formal and informal feedback on visits provided by teams. We asked about the structure and content of reports. We then asked about what followed: about the reactions to the visit and the report, about the structures through which response was co-ordinated and about decisions that were taken. At the same time, we questioned our respondents about other developments in the services concerned, about the impact upon them of other forms of evaluation and intervention, and about competing demands and priorities.

Finally, we asked about participants' perceptions of HAS' authority, values, knowledge bases and objectives.

Although we recognised the emphasis placed by the HAS directorate on the initiation by HAS of a process in the authorities they visited, we paid particular attention to the report as the most tangible product of the exercise using the time series approach described above. In the retrospective studies we asked about actions taken on the report over time. In the studies based on observation of visits, we conducted interviews at particular intervals related to the timing of the visit itself and to the production and receipt of the report. We thus conducted interviews immediately after the visit and for main visits after the receipt of the draft report. We then interviewed people after the receipt of the full report and approximately six months later in connection with the authority's progress report to the HAS. Where possible, we made a quantitative analysis of the response to, and action on, the HAS report recommendations, to supplement the qualitative analysis.

Towards the end of our project, we interviewed policy makers in central government, representatives of other key groups in the policy system and representatives of other evaluative bodies. In the case of the former groups we aimed to find out what use they made of the HAS reports, what their perceptions were of the functions, methods and impacts of HAS and what institutional relationships they had with HAS. In the case of the evaluative bodies we were mainly interested in comparing them with HAS.

4 HAS visits

The organisation of HAS visits

A variety of methods are used in selecting districts for HAS visits. Two thirds of the visits are arranged on a rotatory basis without predesignated purposes, but there have been moves away from that approach towards responding to more specific problems. Districts where particular problems might arise are identified; for example, the 25% of districts with the highest average length of patient stay are likely to have their visits brought forward. Perhaps another 20% (which might overlap with the 25%) are treated out of order by request, or by other modes of selection. For example, press reports might bring the HAS's attention to bear on a particular authority. In this process of selection, the DHSS and SSI are consulted and may occasionally suggest changes.

Care is taken to ensure that there is a proper geographical representation of the authorities visited in order not to overburden them. Exceptionally, it is possible, although never easy, to make fairly rapid responses, perhaps, within three months of an urgent invitation or other expression of a need for a visit. Sometimes, however, a personal visit by the Director has been the form of response either to offer advice needed or see if HAS can help in other ways, perhaps by recommending a consultant who might visit and advise in a more extended visit.

This broad frame is intended to ensure that eventually all districts are visited but that there is adequate response to evident need.

The range of issues dealt with in the course of visits can best be described as largely, but not exclusively, responsive to particular issues discovered at the time of the Director's preliminary visit. It is not the result of any prestructuring of visit priorities according to general policy and practice trends within these specialties in the NHS.

Six months after the report is issued authorities are required to submit an account to the Director of their progress in implementing the advice. Two and a half years after the report is issued a follow-up visit is conducted. The brief for the follow-up teams is specifically to check progress in implementation and not to cover new aspects or issues.

It is rarely possible to visit each district every ten years or to follow up every visit after two and a half years. As we remark elsewhere, the

HAS is parsimoniously resourced and, in our view, does well to achieve the coverage that it does.

Expertise and selection of team members

The Director of HAS selects the medical NHS members of HAS visits. Unlike its Scottish counterpart, the HAS has no permanent members of its own staff on the visiting team and no permanent if revolving group of visitors. They are instead selected anew for each visit from a panel. Many are invited for further assignments but a significant number are not, either because they may not have come up to expectations or because they did not wish to continue.

Different selection modes are adopted for the different disciplines. The Director depends on his own knowledge of geriatric medicine or psychiatry when selecting consultant team members; this is augmented by consultation with professional groups. Contacts are established with the Regional Nursing Advisers and with professional bodies such as the Institute of Health Service Management and the British Psychological Society, who make nominations. Many potential team members are identified in the course of HAS visits.

HAS receives individual applications either spontaneously generated, or in response to HAS advertisements in professional journals. Visiting team members may identify and pass on news of promising members. Although the HAS tends to select well-established and known people, members of teams may identify less conventional practitioners and managers who might make a good contribution. The availability of suitable members does, however, restrict team selection.

Where possible individuals are checked before recruitment to a team; performance on the first visit is, however, the real test. The Directorate try to establish balanced teams for each visit in terms of experience and expertise, but withdrawal at the last moment may require a replacement who might prove to be less satisfactory.

Selection of SSIs

The Social Services Inspectorate is responsible for the selection of SSI team members. They are appointed as temporary inspectors and recruitment depends on informal recommendations and enquiries. They tend to be retired senior managers from social services departments but perhaps too few – when compared with their health counterparts – are seconded from active service in social service

departments. Prospective team members are interviewed and usually undergo a period of orientation which includes meetings with permanent staff with interests in relevant client groups and spending a day or two in one of the regional offices. In common with the retired NHS team members they are required to sign the Official Secrets Act. Those who are approved are listed as temporary inspectors who can be called upon for HAS visits: the current 'pool' is about 70% retired and 30% seconded staff. Very occasionally permanent staff of the SSI conduct HAS visits.

The choice of SSI for a specific visit depends initially on the views of the regional office. Depending on the local situation a regional Assistant Chief Inspector (ACI) may request: someone with particular managerial or practice experience or status; that the same person covers two neighbouring health authority districts; a permanent inspector from the region (although this is rare and an inspector would not be called upon to visit one of the departments for which he has permanent responsibility) because of the need for local knowledge or because of current work with the social services department to be visited. The choice is, then, strongly determined by the regional office but subject to availability.

The quality of many applicants to become temporary SSIs and the problem of turning away unsuitable candidates present difficulties. Advertising or 'head hunting' to try to improve the pool of SSIs available has been considered. The maintenance of quality of SSI members of the HAS teams depends on informal feedback from regional offices, from HAS and from the visited departments through the region. SSIs who are not thought sufficiently able are not called upon again. The expectation is that a retired person 'can be run for about two years after retirement' before the question of being up to date becomes an issue.

The staffing of follow-up visits has been under review and tentative arrangements agreed in May 1986 have not yet been fully settled. In the past, the SSI did not necessarily appoint inspectors for all follow-up visits. The region was asked what level of involvement it wanted, either to comment on progress directly from the region to the team, or that the regional inspector liaised with the HAS team, or that an SSI was appointed to join the team.

The SSI member of a team is seconded to the relevant SSI regional office for the specific visit and is answerable to the ACI. Regions have detailed guidelines concerning the setting up of HAS visits, briefing the temporary inspector and liaison with the SSD to be visited.

The anomaly of having an inspector as part of an advisory team was not apparent in practice in the case studies, or to the SSI.

Permanent inspectors consider their liaison role with the SSDs to be developmental and based on professional peer relationship rather than inspectorial: temporary SSIs on HAS visits are expected to pursue the same approach. At the same time the arrangement is difficult to reconcile with the independent status of HAS.

The members of teams in the case studies came from the following disciplines:

Table 2 HAS team membership in case study visits

	Psych	Geriatric	Nursing	Theraps	Psych	Admin/ Manag	SSI
Case Study 1	1		1	1	1	1	1
Case Study 2	1		2	1		1	1
Case Study 3		1	2	1		1	1
Case Study 4		1	1	1		1	1
Case Study 5		1	1			1	1
Case Study 6	1			1		2	1
Case Study 7	1					1	1
Case Study 8						1	1

While members are chosen for their individual qualities and competence, as might be expected those visited expressed a wide range of opinions about their competence. When criticised, members might have been seen as falling short of what was needed for the particular purposes which the health authority or social services department thought to be the appropriate purpose of the visit, rather than on grounds of their general competence. Whilst the contributions of some were welcomed as providing stimulation and innovative ideas, there were criticisms which included:–

- A failure to cover the full fields of the professions. It was thought particularly difficult for a member of one of the therapy professions to cover the whole range of therapies. It was also thought unlikely that all administrators, drawn as they were now from a range of professional backgrounds, would be competent in the evaluation of planning systems; there is now some stress placed on a strong administrative background in general managers appointed to teams. A further criticism made was that they failed to accommodate to the notion of general management to which health authorities now work;
- in some cases visitors were thought to be inexperienced and not of sufficient status in their profession;

- the tendency to appoint retired (albeit recently retired) practitioners, particularly medical consultants, was also noted, although this is not a deliberate HAS policy and often results from late withdrawals or other unavailability of members still in service.

A further source of criticism derives less from the perceived competence of the visitors than from the structural constraints under which they acted. Leading administrators and practitioners cannot be spared for a long period of preparation and for attendance at visits or for follow up work. More fundamental issues of membership arise when contrasts with the Scottish HAS are made. Uncertainties about the purpose and modes of the visit might perhaps be removed if, for at least part of the time, a core member of HAS staff were present or if the HAS team contained some experts seconded to it for a substantial period. This might, however, produce difficulties of career re-entry in at least some of the contributory disciplines.

We consider later (Chapter 9) the extent to which members' expertise can be linked more strongly with defined purposes of the visit. The possibility of doing so depends upon how far it is thought desirable for purposes of HAS exercises to be explicitly defined.

There are examples of an evaluative body clearing the choice of evaluators with the body being visited: for example, the Chief Scientist of the DHSS has consulted on the choice of scientific advisers evaluating research units (Kogan and Henkel, 1983). NDT does so, too, but pays only a few visits a year. Such a procedure would help ensure that the horses were well chosen for courses but it does assume that there is agreement between HAS and the authorities visited on what the courses are to be and it would be an additional work burden.

Preparation for the visit

(1) The task

An HAS visit requires that several sets of people work together effectively: HAS HQ, the regional office of the SSI, the regional health authority, the district health authority and the social service department(s) to be visited, representatives from the community, and the team itself. These groups represent different organisational, professional and service interests. Preparing for a visit is thus complex and crucial in bringing these different groups together and in creating a setting in which the tasks of the visit can be effectively

undertaken. The arrangements made are largely negotiated. HC(84)16/LAC(84)13 gives guidance on the data to be provided and who might be involved but there is no clear description of the required relationship between the officers of the authorities visited and the HAS/SSI team, although the DHA is, in effect, obliged to receive the team. Effective co-operation depends to a large extent on participants having a clear enough notion of the objectives of the exercise in order to prepare realistically and contribute fully. We present the findings of the study by taking the elements in setting up the visit and analysing the role of each group and the dynamic between them at each stage.

(2) Notification

Confirmation of the precise date, provisional programme and team membership is sent from HAS HQ directly to the regional and district health authorities and to the regional SSI about three months before the visit is due. The letter refers to the visit as a review of services and outlines, in general terms, the kind of advance information to be supplied to the team. The SSI informs the SSD concerned.

Specific objectives for the visit are not spelt out at this stage: it is assumed that authorities know the nature of the work of the HAS and that the visit is undertaken by the team in an evaluative and advisory mode. However, our study identified ambiguities: each participant tended to define the objectives of the visit, usually implicitly, according to his particular experience and perspective. This led to a variety of largely undeclared or unclarified expectations both within and between participant groups.

Following notification, the Director of the HAS arranges a visit to the district to meet officers of the DHA and the SSD. From these meetings he prepares notes for the visiting team outlining the main issues. The Director's briefing was universally welcomed and valued by team members, although the study found some variation in the extent to which the teams then used the items identified to frame or focus their evaluation.

(3) *Setting and arranging the programme*

The many practical arrangements to be made fall primarily to the DHA. The outline programme given by HAS HQ follows a broadly similar format. The preliminary programmes typically include multi-disciplinary meetings, meetings with operational staff, visits to

service sites and meetings with community representatives: they tend not to specify individual meetings.

The programme is usually subject to several revisions and additions which may originate from team members, from staff of the authority and from negotiation between the DHA and the SSD. Liaison officers are usually appointed to organise the programme and communicate with the team but there were no examples of senior managers or officers meeting to establish an overall approach to the visit and prepare in some co-ordinated or overview fashion. Although it is largely left to the authorities to decide who and how many people should attend the various meetings there was little evidence that this discretion was used in a strategic way, for example, to highlight particular aspects of the service, to demonstrate multi-disciplinary or inter-agency links or to ensure that an appropriate combination of posts and organisational levels were represented to discuss specific items. Senior managers usually saw preparation for the visit as an administrative task and left this to more junior liaison officers. Given the extent to which the pattern and membership of meetings, site visits and individual meetings can affect the range and content of the information received by the visiting team, it is significant that authorities did not, on the whole, take more initiative.

There was no lack of ideas about whom and what the team should see. Many of those interviewed expressed critical views about the team's programme (for example, gaps in coverage, the composition of meetings) but had rarely tried to intervene or make their views known.

Team members varied in how far they sought to control the programme. There were examples of members who complained about the organisation of the visit ('too full a programme', 'too building orientated'), but had not attempted to negotiate different arrangements. Some added a substantial number of items to their programmes. It appeared that visiting teams expected the health authority to have a clear idea (and one congruent with those of the team) of their requirements and approach. There were general criticisms from team members about the lack of time available to cover the ground – a common complaint of visiting teams in all areas of evaluative activity. Equally, there were mixed views about the desirability of predetermining a focus on specific areas in order to ensure study in more depth. Pre-planned programming left little room to tackle things as they emerged: members felt they had minimal control over the programme before the visit.

The intention is to allow for comprehensive coverage without

preventing teams from pursuing specific topics. The actual programme is thus substantially determined prior to the visit and is based on a generalised format which may not best serve the needs of the specific district or visit.

(4) *Preparation and dissemination of prior information*

All teams in the study received prior information from the DHA; not all had information from the SSD. The quality, relevance and amount of such information, as reported by team members, varied considerably. As with setting the programme, several perspectives are involved in preparing material, each based on interpretations of the HAS HQ original brief: the information that individual team members wish to receive; what the authorities believe they want and what the authorities wish the team to have. Team activity in itemising and obtaining the information varied. In the two follow up visits, the administrator member took a lead in specifying the information they required from the DHA, although neither communicated directly with the SSD. Both failed to obtain prior information from the SSD. In each case the administrator member was prepared to take a lead before the team had convened. It was not clear from other visits that team members had taken any initiative in specifying the material they wanted. Some individual members spoke of gathering information informally about the district. SSI members usually obtained information by meeting the permanent SSI at the regional office before the visit began.

DHAs in the study had all provided material for the HAS visit although this was usually a collection of existing documents rather than prepared with the visit in mind. In some instances consultants had got together to present material and some sent comment individually. In none of the cases had there been an attempt to coordinate the material sent from different groups within the DHA.

It might be difficult to create a balance between adequate collation of material and allowing it to arise from several sources. It seems right, however, that authorities should provide a systematic collation of trends and policies which can then be modified by individual or group contributions on specific issues.

SSDs varied in the amount of attention given to the visit and some did not provide advance information. In one example, however, the SSD saw the visit as an opportunity to discuss progress on joint planning and had been eager to present the team with a jointly prepared briefing pack. In the event this was not achieved but the SSD did furnish the team with a specially prepared collection of

papers which included a resume of what they saw as the key issues. Another SSD had prepared an updating report for the follow up team but had not thought it necessary to present this ahead of the visit. Generally, communication between the DHA and SSD was confined to arranging the programme: there were no examples where joint material was presented.

Community Health Council representatives, in contrast, displayed a more active approach. Usually they had prepared a written statement of their main concerns as well as expecting to put these to the team in person.

There are seven formal sources of information and comment for the team: the Director's brief, the regional health authority, the DHA, the regional SSI, the SSD, community representatives and individuals, in addition to informal or personal sources and published material. Members questioned the amount of information which they could effectively digest beforehand. Many considered they had too many papers and used the material for reference during the visit if at all; others considered they were inadequately briefed.

There were, then, two broad responses to the general request for information in the HAS letter of notification; one a passive collation of existing material without special reference to the purposes of the visit; the other an active preparation drawing the team's attention to particular items. Equally, team members displayed a range of attitude from passive receipt of material to active involvement in clarifying what they needed.

We conclude that providing information before the visit was not seen by authorities as a critical means of briefing the team, orienting their approach or starting a working dialogue. But team members found this a vital means of understanding fundamental aspects of the district if they were to make the most of the time available and some expressed their frustration at over-lengthy, unco-ordinated, inaccurate, inadequate or undigested material.

The kind of information which members of visiting teams sought covered the following:

- an account of the main characteristics of the locality, i.e. demographic, social and political features;
- the context of local services, patterns of development and resources;
- organisational structure (including joint planning systems) and main sites of the DHA and SSD;
- statistics, for example, staffing levels, beds, occupancy;
- key policy statements;
- a digest of the financial and resource position;

– a summary of the main issues or problems as seen by the authorities.

Members emphasised the value of succinct and specially prepared material.

In part the difficulties may arise because of a lack of clarity about who has the prime responsibility for arranging and resourcing the visit. Is it the team members who know what they want and in what form? In this case how should they co-ordinate and communicate their requirements? Or is it the HAS which acts as the prime mover in establishing the visit? Is it for the authorities to decide on the content? As we have indicated there is scope for them to influence the structure, pattern and content of their participation. The answer perhaps depends on when the visit is deemed to start. But there is little doubt from the study that the manner and content of notification and preparation strongly determine expectations and therefore the shape, scope, working relationships and methods of the visit for all concerned.

For the most part it was the presentation and lack of critical collation rather than the lack of material that was the problem. The obvious solution, of HAS HQ staff appraising material to ensure that the content and format were adequate, would, however, mean a closer involvement in determining the purpose of the visit and would require a substantial addition to resources, as well as making space in a tight preparation period.

(5) *Expectations of the visit*

Interviews with nearly all those concerned showed that they had formed expectations of the visit and what it could achieve. Although made explicit either within an authority between different professional groups or between officers and team members, it was clear that such expectations influenced the work of the visit and the interaction of participants.

All local staff interviewed had their own agenda of items which they considered the team should address. These items varied according to professional background and seniority but in the cases studied there was usually a degree of internal consensus about the main problems. In some cases senior officers had met (usually immediately before the visit) to clarify the main points which they wished to present but these did not usually include views from different units or levels in the authority. Rarely was any systematic briefing provided for staff in the authority who would meet the team on site visits or in multi-disciplinary meetings.

We can note, therefore, that the occasion of the visit was not used formally by the DHA, still less by the SSD, as a means of initiating or stimulating *in house* discussions prior to the visit although this is one of the real values of the HAS exercise according to many. Visits did, however, prompt practitioner group meetings to discuss issues and decide on the comments they would present to the team.

In general, it would be fair to say that local expectations of HAS visits were not always met in practice. One authority, for example, hoped there would be a 'developmental' approach enhanced by interaction and discussion with team members. In the event, the team was primarily inspectorial, perhaps because there was little time for anything else. The social services department had wanted comment and advice on the planned reorganisation of hospital social workers and affirmation of a joint planning machinery but these large issues, it was felt, had been largely missed.

In another, the Director's brief identified what he and the District General Manager had noted as the main problems. The district had approached HAS for help and to meet its concern with the concentration on the use of beds, the need to shift care from the institutions to the community, relationships between health and social services and the standards of nursing care. The district's expectations were perhaps unrealistic in that they wanted something more like management consultants. But in this case, too, the team was not seen to function as a group with a shared purpose. Members were felt to keep to their own disciplines and not to have an explicit way of evaluating the service. Social services staff saw HAS staff as mainly concerned with health and there was some uncertainty about its role. It was not felt to have a systematic methodology.

In another visit the health authority had identified as issues the relationship between the SSD and the health authority, several operational problems such as recruitment and the skills of staff, lack of interdisciplinary working, problems of closure of the hospital. It was hoped, however, that the team would focus on strategic issues concerning the development of community services. In this case, too, it was not felt that the team dealt thoroughly with the obvious problems.

In a further case there were strong divergencies in assumptions about the visit locally both among the hosts and between them and the visiting team. Interviews before the visit indicated agreement on the main issues which were the development of services within the health district. Respondents were concerned with the extent to which the plans for transfer of services from a neighbouring district were realisable and correct. There was also concern about the

management arrangements for the new service and there were doubts about management being on too piecemeal a basis. There was concern about the relationships between health and social services and the quality of joint planning. These issues were, in fact, those pursued by the team. But it transpired that the managers had expected the team to look at what was being done now to give guidance about the future. The medical staff, however, hoped for reports on the levels of patient care that should be adopted. In this they were disappointed.

The process of the visit

(1) *The focus and orientation of the visit*

The HAS sets common objectives for main and follow up visits. These assume an advisory and developmental approach to which tasks of inspection, monitoring and review are subordinated. But the terms of reference are broadly stated and require interpretation and detailed specification for each visit. It is doubtful if any team could, for example, in the time available, adequately cover the full brief given in the guidelines to team members (HAS, *A Memorandum for Team Members*, June 1987).

The universal means by which the main issues could be identified and relayed from officers of DHA and SSD to the team was the preliminary meeting with the Director. These meetings served as a channel of information between the authority and the HAS and the Director acted as a filter and interpreter.

The majority of team members referred to the importance of the Director's briefing as an authoritative view of the issues which also drew on authorities' own understanding of the problems. However, team members also displayed a firm independence. Many thought that the issues could emerge only from the process of the visit and could, or should, not be pre-defined. Others were concerned that their own expertise and experience should inform the focus taken. Thus, the Director's brief was a key element in identifying the main issues but fell short of determining the focus.

In two cases (a main and a follow up visit) the team had met the District General Manager (DGM) before the first formal meeting to obtain his views. Contact like this and the SSI's visit to the regional office influenced a team's approach but did not appear to strongly affect the agenda for the visit.

Individual members came to a visit with particular aspects they wanted to pursue: some of these were specific to the district and were

derived from reading preliminary material, but mostly they related to aspects of their own area of professional practice and service aspects of management or policy directions. It was these individual interests, rather than a developed team perspective, which most strongly framed the approach to, and outcomes of, the visit.

A further factor influencing the focus taken by teams was the HAS format for writing the report. This requires teams to frame their advice in a particular way which favours, for example, disciplinary and service areas rather than multi-disciplinary, joint or integrated work.

District staff referred to teams having particular outlooks. For example, one was described as 'pursuing typical HAS lines', i.e. orientated to the development of community services, pushing multi-disciplinary work and joint planning; one was seen as 'too hospital based', another as interested in moving to community services. Some of these comments do not, of course, do more than complain that the teams were in line with common professional and policy assumptions.

Most teams did not set a focus or identify key issues before the visit started. The reluctance to do so was explained in several ways: it could be unfair to the district by, in effect, prejudging the issues, it could be inaccurate; those feeding in opinions prior to the visit were not necessarily in a position to know the detail of the situation, professionally informed views of the team members should be taken into account. Even where an authority had requested the visit, the team resisted accepting the district's frame. Teams tended to form a consensus about the main problems in the course of their work but, equally, there was at least one case where no focus emerged.

Tables 3 and 4 contain an analysis of the numbers of recommendations in the main reports associated with our case studies according to professional and practice areas broken down into professional-practice and functional areas. They are then shown as a percentage of the total number of recommendations in each report. A simple numerical count of recommendations cannot accurately reflect the true importance given to each area. Bearing that reservation in mind, the following points emerge from summary tables, which also accord with the impressions derived by the evaluators from the eight case study visits, and the critical observations of some of those visited.

There are substantial differences in the percentage of the total number of recommendations in respect of both functional and professional and practice areas. The most substantial variations are in the numbers of recommendations on patient and support services (a range of 4.6% to 22.7%), and patient care and professional practice (2% to 13.6%). The areas least attended to are strategic

Table 3 – Analysis of recommendations in main reports – functional areas as a percentage of total number of advice paragraphs in each report

	CASE STUDY							
	1982 MI %	1983 E %	1984 MI %	1985 MI %	1985 E %	1985 E %	1986 E %	1987 MI %
FUNCTIONAL AREAS								
Material/Physical/Environment/Facilities/ Equipment	12.4	10.0	14.7	12.5	21.6	21.9	16.8	13.6
Patient and Support Services	17.0	8.3	8.5	4.6	22.7	2.0	12.6	1.4
Staffing: Recruitment/Level/Deployment	15.5	21.6	24.0	13.6	11.5	22.4	12.1	21.4
Patient Care and Professional Practice	5.7	8.3	10.2	5.0	10.8	2.0	3.3	13.6
Operational Management	21.6	35.0	16.5	23.9	15.8	22.4	20.5	17.8
Joint Work	5.7	——	11.4	17.8	4.3	12.2	18.0	13.6
Strategic Policy and Planning	9.8	11.6	2.3	1.4	3.6	3.1	2.5	3.6
Joint Planning	7.7	1.6	10.2	7.1	3.6	8.2	6.7	12.1
Training, Staff Development, Research	3.1	3.3	1.1	8.6	6.1	5.6	7.5	1.4
Finance	1.5	——	——	5.6	——	——	——	1.4
N =	97	60	88	140	139	98	119	70

Table 4 – Analysis of recommendations in main reports – professional and practice areas as a percentage of total number of advice paragraphs in each report

	CASE STUDY							
	1982 MI %	1983 E %	1984 MI %	1985 MI %	1985 E %	1985 E %	1986 E %	1987 MI %
PROFESSIONAL/PRACTICE AREAS								
Medical	10.3	31.6	17.0	15.0	5.0	12.2	5.5	10.0
Social Services/Social Work	11.3	3.3	20.4	9.3	9.0	10.2	26.0	10.7
Therapy/Parademical	3.6	13.3	5.7	18.2	16.5	24.5	16.0	7.1
Nursing	17.5	21.0	7.9	17.5	15.5	12.2	14.3	7.1
Ancilliary	4.6	——	3.4	——	12.2	——	2.1	——
Multidisciplinary/Multi-Agency	7.7	6.6	13.6	9.3	10.1	13.7	13.4	19.3
Administration/Management	39.7	18.3	13.1	28.2	14.0	8.7	18.1	32.8
Health Authority	5.2	5.0	16.5	0.7	17.0	13.3	2.9	12.1
Local Authority	——	——	2.3	0.8	0.7	5.1	1.1	0.7
Other	——	——	1.1	——	——	——	——	——
N =	97	60	88	140	139	98	119	70

policy and planning and joint planning, training, staff development and research and finance. It is fair to note that these latter areas tend to be concerned with large and global issues and may be less likely to give rise to detailed and numerous recommendations but comparison of the attention given in argument and discussion in the reports across the studies shows marked differences in the emphasis given within each area.

It is difficult to trace the reason for these differences; they do not entirely follow the issues and problems in the district as identified beforehand by the Director, the DHA or SSD or to those identified to us subsequent to the visit. A comparison of earlier and later reports does not suggest that differences relate to the time of the visit. The two strongest links appear to be first, the context: the nature of the service and its particular circumstances. Thus if the district has a large mental hospital the team may concentrate on service delivery. If a hospital is to be closed, the team's attention will be directed towards the adequacy of planning arrangements. A second link appears to be the composition of the team: the emphasis of the visit, to the extent that this is revealed in the report, corresponds with the professional background, interests, experience and personal authority of individual members.

Comments from district staff suggested that teams generally lacked a strategic or planning view although in one case the visitors were thought to be too concerned with critique of planning at the expense of service delivery. Interviews in the authorities showed that district managers and SSD directorates were looking for comment and advice on strategic issues, on the direction and management of change, on national policy. Professionals too are recognising the impact of stronger management models and are looking for more involvement in planning and decision making processes. Comments from staff raised questions about the orientation of HAS teams; managers in particular wanted HAS teams to focus on and give advice at a strategic level rather than concentrate on service aspects; criticism from several authorities centred on a team's lack of attention to or understanding of policy, planning or management issues.

Table 5 analyses those advice paragraphs in the eight main reports which referred to services in the community according to the level of commitment required. They are shown as a percentage of the total number of recommendations. The table shows that the latest visits pursued community development most strongly. Overall, however, recommendations were weighted to improving liaison and planning, or augmenting existing services rather than promoting a shift from

Table 5 – Analysis of recommendations in main reports – Community orientation: expressed as a percentage of total number of advice paragraphs in each report

	CASE STUDY							
	1982 MI	1983 E	1984 MI	1985 MI	1985 E	1985 E	1986 E	1t87 MI
RECOMMENDATIONS EXTENT OF COMMITMENT								
Improve liaison with/community based practictioners and/or involve them in planning	(4) 4.1%	(4) 6.6%	(9) 10.2%	(11) 7.9%	(3) 2.0%	(3) 3.1%	(15) 12.6%	(1) 1.4%
Improve/extend existing community based services	(2) 2.1%	(–) ——	(4) 4.5%	(7) 5.0%	(5) 3.4%	(11) 11.2%	(24) 20.2%	(10) 14.3%
Promote shift from hospital to community based services and/or create new community programmes	(2) 2.1%	(–) ——	(3) 3.4%	(5) 3.6%	(1) 0.7%	(2) 2.1%	(22) 18.5%	(13) 18.6%
Promote use of joint finance or use of health authority funds for community services	(1) 1.0%	(–) ——	(–) ——	(2) 0.2%	(–) ——	(–) ——	(7) 5.8%	(–) ——
Totals	9	4	16	25	8	16	68	24
% =	9.3	6.6	18.2	17.9	5.8	16.3	57.1	34.3
N =	97	60	88	140	139	98	119	70

hospital to community based services or developing new community programmes.

A critique of HAS visits (Nitsun, 1988) complains that the HAS visits do not note sufficiently the way in which the pattern of services is changing from a hospital to a community base. 'The problems of these services are often problems of transition and organisational change. Any review must be clear about where its focus is directed and to what extent it is cognisant of the changes in service delivery'. He notes that, in a set of HAS visits which he experienced, at the time of the first visit scant attention was paid to the community and the follow up visit ignored the fact that a retrenchment policy had been drawn up for the hospital. 'The skewed emphasis of the first visit was exaggerated by the even more skewed emphasis of the second'. He also notes reports of visits from other districts where teams are said to have 'strongly encouraged the closure of hospitals and the development of community facilities, while others appear to have accepted or reinforced the role of the hospital as the centre of the service'. This criticism touches upon a concern which we deal with elsewhere in the report, namely, the extent to which the HAS and its teams do or should bring with them assumptions about patterns of organisation and models of care into their evaluative frame.

Finally, we note that, apart from the Director's meeting with officers and with the team, little time was given to prior discussion about the focus and orientation of the visit, within teams, between teams and the authorities or, as noted earlier, within authorities. Several commented on the need to focus to make visits effective: more definition could help teams to work together in a multi-disciplinary mode and encourage more active collaboration from the authorities.

(2) *Working as a team*

Team members had not met before the visit and had quickly to learn to work together. The tasks for the first team meeting were:

- to consider the main issues or focus of the visit;
- to allocate tasks;
- to agree coverage of personnel, sites and areas of services;
- to consider the approach(es) to be taken.

Most teams allocated tasks, without much discussion, according to areas of professional interest. Where a profession was not represented coverage was agreed on the basis of who knew most about the missing area. Some teams attempted to define their tasks in relation

to an integrated service approach and to cover the ground jointly but found this difficult to sustain in practice.

Members did not refer to difficulties about coming together as a team; most felt that a satisfactory level of agreement about how to proceed was reached fairly quickly. Relaxed, friendly and open working relationships were based on respect for each others' professional background. Many members were critical of, or could see the drawbacks of, working as a collection of individuals – it was recognised that this restricted the use of cross-disciplinary and inter-disciplinary perspectives – but had found no solution to this.

The clearest division of work was between the SSI member and the rest of the team. In all cases the SSI took the lead in all contacts with the SSD; in some cases only the SSI met SSD staff. At the same time most SSIs involved themselves with hospital visits and staff at all levels in the health authority. Some SSIs in the eight case studies felt their colleagues did not take enough interest in the SSD especially when future service development involves community based resources.

Coverage was thus based on the disciplines. The rationale for this was that credibility and authority were seen to reside in the competence and status of the individual professional: team credibility derived from the calibre of its members rather than from its performance as a team, although a weak member would clearly be noticed.

We found no example where a team decided to allocate 'housekeeping' tasks. For example, the Chair for meetings was usually decided but no one was designated to keep a record of each meeting. In the visits observed it was noted that it was difficult for members both to listen and take notes, to keep track of who was who, to keep a watch on time and to handle papers.

Leadership tended to fall to the administrator or consultant on the team although in some the leadership rotated according to the composition of meetings on the list. The critical time for the exercise of leadership was at the start, when experienced members could seize the initiative. Most teams designated someone to act as co-ordinating editor for report writing.

(3) *Working within the district*

We referred earlier to the complexities of making arrangements which brought the different groups of people involved in the visit into a working configuration. In order to fulfill their brief, team members met people working with, providing services for or with an

interest in, the elderly or mentally ill in the district. Such people came from a number of agencies, departments, professions and units:

- the district health authority which included managers and members of different professional groups and staff from all levels;
- local authority departments which covered the district area: social services, housing and education departments;
- community representatives such as the CHC, voluntary agencies, general practitioners, bodies representing patients and their carers.

ENGAGEMENT

The study suggests that most teams and authorities spend little time in preparing the ground to ensure that people meet with a clear understanding of the purpose, scope and methods of the visit, what is expected of them and how they may use the visit. On the evidence of the study, within the DHA and SSD it is not usual for staff to be involved in discussions about, or briefing for, the visit. But it could be argued that the HAS objectives of, for example, helping authorities in 'building constructively' and encouraging 'co-operation between agencies' might be better served by establishing a more shared approach through involving key personnel and actively recruiting commitment to the exercise. There are several elements in this.

First, team members need to have a sufficient grasp of the social and political context of the district they are visiting, its characteristics, its particular problems or achievements. They also require some understanding of the working arrangements and relationships between the agencies and departments involved. They pick up these points en route but they are not presented at the time when they are first forming their approach.

Second, expectations of the visit are set up by the first notification. Preparation by different interest groups is concerned with briefing the team and collating comments but also with using the visit to get across points of view to other agencies/ professionals. A team thus enters a network of existing inter-departmental and professional relationships and a complex of expectations about the outcome of the visit. This is inevitable and may be a good in itself but some clarifying reduction of expectations would help sharpen the focus of all concerned.

Third, a team's credibility within the district rests, as we have suggested, on individual status and experience. In the studies authority staff rarely knew much about the members of the HAS

team unless they had done some homework or knew an individual from previous work or other contacts. Individual reputation could make a significant difference as we saw in one follow up visit where the administrator was known and respected by the DGM.

Fourth, establishing common understanding of the purposes, scope and methods of the visit is a means both of orientating people and of recruiting their goodwill and commitment. It is also a means of creating a climate or working culture for the visit which enables people to interact effectively and in a way that is consistent with the objectives of the visit.

Few teams took steps to clarify expectations and work approaches with the authorities other than to make a statement at the beginning of each formal meeting. The processes of notification, preparation and engagement, as currently handled, both by the HAS and internally by the authorities, appear to result in a broadly reactive stance: local staff are recipients of the HAS visit – team members know what they want to find out and it is their job to ask the questions, see the sites and seek information. One result was that staff tended to play safe and assume that the visit would be inspectorial and summative in effect, if not in intent, and this led to a more or less defensive response, perhaps heightened in cases where the report was to be published.

STYLE OF INTERACTION

Some teams were more successful than others in establishing the kind of collaborative, discursive interactions with staff which were consistent with an advisory, developmental approach. This was, however, more related to individual style than a team approach.

The style of interaction varied between members (often different staff spoke of the same visit in very different terms according to whom they had met) and led to different responses. There was a range of styles including the inquisitorial and confrontational, the reiterative and discursive, the didactic, the relatively open-ended, passive listener/onlooker; some gave room for local staff to take the initiative, others followed their own lines of questions.

METHODS

The range of methods employed by teams also varied widely. There were those which relied primarily on observation and listening, others actively cross-checked views and information; some entered into dynamic discussion pointing out, for example, inconsistencies within and between DHA and SSD. Meetings, again, were structured

differently according to the way the authority had set them up, their composition and degree of lead given by the team.

Teams had a variety of concerns. They were seeking evidence on which to base assessments of the services; they needed to gain understanding as a basis of advice they might offer; they aimed to engage with staff in order to elicit ideas about issues and their possible solution, to encourage staff, particularly those where morale was low or conditions poor and to sound out their own developing ideas.

At the same time there were differences of view in the teams about the purposes of documentary information, particularly that provided in advance by authorities. Some wanted it primarily to help them identify the focus for the visit and the main issues of concern in the authorities. For others it was a key means of assessing the relationship between needs and resources and a basis for the development of advice, particularly on strategy and planning. Others wanted to make comparative assessments of performance, (HAS do furnish team members with national statistics on a number of performance indicators) and thought regions should provide (as some did) a picture of how an authority compared in its provision with other districts.

The quality of evidence was a cause of concern amongst team members and critics of HAS in our study. In one of our visits difficulties arose from the problem of verifying a key set of figures, crucial to the task set for the visit by the health authority, which was to advise on the model of service and on strategic planning. The problems derived from a combination of failure on the part of the authority to supply particular sources of evidence before the visit and conflicts of evidence. We observed team members trying to verify statements of need and criticism between groups or to establish the prevalence of particular perceptions or concerns. Some used site visits partly to verify statements made in meetings. It is probably significant that a team amongst whom there were serious conflicts were unable to incorporate some issues in their report because they had insufficient and irreconcilable evidence about them. They had been disabled in using each other as sources of verification.

Critics of the HAS visits in the study linked quality of evidence with the structuring of visits. Teams were observed by some as having no clearly defined structure and purpose in their investigation and in consequence as picking up arbitrary evidence or evidence biased towards the people 'with axes to grind' (cf correspondence in the *Bulletin of the Royal College of Psychiatrists*, 1986).

But teams are required to be responsive as well as taking the

initiative. The HAS was set up partly as a body to which those who could not, or who feared to, give effective voice to their views could have recourse: a means by which poor standards of care, abuse or scandal could be brought to light. And a process which is seen as exploratory, designed to draw out issues and solutions from those visited, assumes a mode which is reactive as well as proactive. Such a process is not wholly compatible with one designed primarily to produce objective, authoritative judgements.

COVERAGE

Coverage of sites, services and local staff posed problems for all teams arising partly from lack of time but also from a lack of focus.

The standard approach was to use the programme of formal meetings, multi- and mono-disciplinary and multi-level, as the main vehicle for obtaining views and comments. This was then augmented by selected site visits where the teams relied significantly on the authority to identify the relevant wards or homes. Individual meetings, usually with senior staff, managers and consultants, rather than key operational staff, were often set up during the visit as they were available. As noted above, fitting in extra visits or meetings in order to cover points or queries which emerged during the visit was a problem for teams, although many members succeeded in making contact with people in their own professional groups.

There was no consistent pattern to site coverage or the composition of meetings: these appeared to depend on frames of reference used by the authority in setting up the meetings, for example, between services, units, professions, levels of staff responsibility or sites.

MEETINGS

Teams conducted different types of meeting which are presented in the following matrix:–

Figure 3 Types of meeting

	Multi-disciplinary	Single Discipline or Interest	Inter-Agency
Multi-level			
Senior level			
Operational level			

The use to be made of each type of meeting did not appear to be particularly thought out by teams or by authorities. This led to duplication in some of the visits we observed, instances of team members cutting across each others line of enquiry, repetition for staff and missed opportunities to focus on specific issues with a particular mix of staff. For example, local staff were only afterwards aware of the potential value of discussing a problem with the team given the people present – perhaps a combination unlikely to occur in the course of everyday contacts.

There were criticisms of multi-disciplinary and multi-level meetings: staff told us of meetings in which they had wanted to speak freely to the team but were cautious about doing so in front of particular colleagues or staff of another agency. Team members were often aware of this kind of self-censoring but, indeed, could benefit from the glimpses of internal or inter-agency difficulty which emerged from tensions between those present. Such information was recognised as idiosyncratic but could alert the team to make further enquiries. These meetings tended to be led by the team in a more or less structured fashion. They sometimes provided the team with an opportunity to discuss multi-disciplinary and inter-disciplinary issues and promote joint working. Some members spoke of wanting to foster vertical communication within the DHA and SSD as well as laterally between units, professions and agencies. It is doubtful, however, that relatively short, one-off meetings with the team could realise such outcomes. Indeed, in relation to multi-disciplinary and joint working there are internal resistances to this kind of shift. Staff derive power, influence and identity from their professional group which could be eroded by integrated approaches to service provision.

Mono-disciplinary meetings tended to have a different flavour. Here it was more likely that the local staff would be given or would bid to take the initiative. In meetings with powerful groups, such as consultants or senior managers, the visiting team were more likely to be reactive to the information or views presented. We noted instances where there were strong bids to influence the team to take a particular line: in one case this amounted to a group of consultants attempting to dictate their recommendations to the team. A different example concerned a SSI member meeting on his own with middle tier staff of a SSD. Here it appeared that the SSI was anxious not only to understand their problems but also to take their part in explaining these to his team colleagues and critical DHA members. Was this an instance of a team member being over-identified with his profession? The general point to emerge is, not surprisingly, that a team may be subject to significant pressures from particular lobbies of interest.

On the whole, we found that the meetings which were both most appreciated and most criticised by local staff were those between them and the team member of their own profession, depending on their competence, expectations and performance. It is at this level that staff expect to benefit most from the visit and members expect to have most to offer.

SITE VISITS

The range of health service sites visited by the teams observed was limited largely to hospital based services. Thus all teams visited some hospital wards; some, however, also went to specialist units such as therapy departments or hostels. Social services sites visited might include a hostel, old persons' home or day centre.

Team members approached visits to service sites differently according to their outlook. For example, one SSI was concerned to look at the daily pattern of life for the patient and to assess the quality of life experienced on a ward or in an old persons' home. A different approach, from a nurse, focussed on nursing practice and ward organisation. Another member, a physiotherapist, was keen to check that the physical environment and facilities were of an acceptable standard. Of these examples, the first is the more difficult to assess from a 'snap-shot' visit; the evaluation of quality of experience depends on gaining knowledge over a period of time. Those aspects which can be assessed visually tended to feature most clearly in the recommendations: laundry arrangements, meals provision, bed and locker space. Social interaction, the quality of contact between staff and patients and between the disciplines, the culture of long stay wards, the quality and content of communication between staff, patients and relatives, staff morale – these were of concern to team members but hard to assess. One or two teams arranged second visits at different times of the day (and night) to try to see more of the working arrangements and ambience of a ward.

Site visits were an opportunity for members to talk to staff but, on the whole, members did not engage in lengthy discussions and it seemed a matter of chance whom they met and what they heard. There were staff who were ready to talk to the team but had little chance; there were also those who made sure of getting their say but most staff were reactive. Few members took the opportunity to speak to patients; it appeared that patients were generally unaware of who the visitors were or why they were there.

A main criticism from operational staff was that there had been insufficient time for the visiting member(s) to see the work of the ward or unit at all properly, to check their perceptions through

discussion or take note of the points or criticisms which staff themselves wanted to make. Many were more critical of their own aspect of the service than the team had been and more specific in their ideas about remedies; many also considered themselves more up to date and forward looking than the team about issues of practice and the organisation of services.

The coverage of SSD services varied but, we concluded, tended to reflect an assumption that the emphasis of an HAS visit was on health services. SSD provision was looked at to the extent that its services interfaced with or impinged on health.

On the whole, team members valued site visits and thought they could obtain a reasonably accurate idea of the most important features through seeing for themselves; they could then follow their professional noses.

(4) Presentation of advice: framing and feedback

We have seen that one of the first tasks of an HAS team on a visit was to allocate responsibility for writing various parts of the report and that allocation was heavily discipline based.

The *Memorandum of Guidance* encourages teams to start writing the report during the visit. Progress on this varied with the length of the visit but all teams prepare notes for the final, feedback meeting with officers which cover the main conclusions and advice to be offered by the team.

The ground for formulating recommendations was laid partly in team members' individual meetings with staff from their own profession and other groups for whose advice they had accepted responsibility. Relationships established in those groups were important for determining how far advice could be collaboratively formulated with staff. Teams varied widely in how far they achieved this.

Team members shared their perceptions of disciplinary areas with their colleagues and we observed instances of challenge within the team to individuals' criteria and perceptions. For the most part, however, members were constrained by the boundaries of professional expertise.

On the larger issues teams did check and discuss their developing ideas and shared experiences through daily meetings. Most stressed the importance of the team meetings and attended them conscientiously. Members did not always agree on how strongly to frame their criticisms and advice: some were clear that the DHA was usually well aware of shortcomings and would be supported by

strongly worded advice in negotiating change and resources; others thought staff could be demoralised and put off making changes if criticism was too strong. Authority staff were often more robust; they wanted firm messages about the need for change, although they wanted to be credited, where appropriate, with alerting the team to the problems. There were conflicts within authorities about what was expected, perhaps particularly between managers and practitioners or professionals. Conflicts in expectation were about style and substance. For example, in one of our case studies, managers wanted a clear analysis of the problems arising from the clinical organisation of the service, to expose the costs and benefits of different clinical practices; clinicians wanted recognition of the resource difficulties under which they were working and judgements that would not further undermine professional morale. One group wanted an unequivocal judgement, to clarify accountability; the other wanted understanding and support.

These conflicts created difficulties for members. However, for the most part, members managed to reach agreement amongst themselves and worked hard to resolve conflicts in the team over major issues. In one of the visits in our study this did not happen and the team had to refer the matter for consideration by the Director after the end of the field work.

Teams are encouraged to meet senior managers of the health authority and the social services department informally towards the end of a visit in order to ensure that there are no major surprises or significant errors of fact in the formal feedback. Verbal feedback to the authorities of the main points of advice from the team is given at the final meeting. Those invited to the initial meeting are expected to attend, together with (at least) key staff from all the authorities concerned. It is an essentially formal occasion centred on the team's presentation of its main conclusions. While correction of any factual errors in feedback is welcomed, along with general comments on the visit, debate on the issues raised is not encouraged. (HAS, Memorandum for Team Members, 1987). The aim is that authorities will be left with as clear an understanding as possible of the team's advice prior to the receipt of the draft report. It should be noted that since our study visits an experimental project is testing alternative arrangements.

Of all the stages in the visit, the feedback meeting provoked the most anxiety amongst teams and most criticism from those visited. It also often left the strongest impression. Feelings about the visit were coloured by reactions to this occasion. Thus, as the format and style were overwhelmingly those of a summative evaluation, many staff

were left with the impression that the visit had been predominantly an inspection. Moreover, because the presentation was strongly discipline based, with each team member making his or her own presentation, many people experienced the feedback as fragmented, rather than offering a model of multi-disciplinarity as the HAS directorate hoped.

Teams were sensitive to the conflicting expectations laid upon them and found it hard to agree on the balance to strike between giving clear, unequivocal advice and sustaining morale amongst staff not necessarily giving an effective service.

Our experience suggested that the aim of leaving authorities with clear advice was not easily achieved. People sometimes heard different things and took away different messages.

Visits had covered an extensive range of issues. The task of presenting findings from a concentrated visit, with participants from a range of organisations and groups with different perceptions and aspirations, was a formidable challenge. It was not surprising that some feedback meetings were experienced as rushed and the teams either as not fully in control of the event or as being over-didactic and uncompromising.

The feedback meeting was the point of the visit where the dangers of inconsistencies in the process of the visit and of underestimating the complexities of demands upon teams were exposed. People could not understand why, in a process that was intended to be collaborative and interactive, that mode was abandoned at a key stage. And it was at this key point that teams who had not been able to work together or who had not understood the local context found it hardest to come across as credible and having something of value to offer.

These reflections will be taken up in chapter 8, with a closer look at the evaluative models underlying HAS policy and practice and authorities' perceptions of its work.

(5) Preparation and publication of the reports

The HAS conducts an average of 40 main visits a year, each producing a report of about 60 or more pages.

Following the visit, teams meet for a week at HAS HQ to write the report. Team members are expected to arrive with prepared material which can be typed on the first day for team circulation. By the Thursday all individual pieces should be in place to form a final composite draft by the Friday. This is the final work of the team: members do not receive a draft or see any subsequent versions as it

goes through the process of checking and editing by HAS secretariat and the Director.

Editorial responsibility has been taken by the Director and Deputy Director of HAS. The process has involved detailed checking of reports for consistency of style, presentation, organisation of contents and to eliminate any emotive or political statements, ambiguities or typograhical errors, etc. It was emphasised that it was not the intention to alter the content or the opinions expressed; the aim was to produce a clear and readable document.

The Director sends the draft report to the SSI regional office for clearance though additional editing rarely results. The draft is then sent to the regional and district health authorities by the HA and to the SSD by the SSI Regional Office for correction of fact.

Valid corrections from the authorities are incorporated. HAS HQ then prepares a final version for printing by the DHSS.

Should the report contain something of particular concern the Director will alert the DHSS at the draft stage. The DHA and SSD are notified by HAS HQ when the report is ready; it is their task to decide on a date for publication and to arrange press releases. The HAS then arranges for copies to be circulated to the Secretary of State, the House of Commons Library, some newspapers (for example, *The Guardian*). The Chief Inspector of SSI has first sight of the report at this stage; although he is a co-signatory, the effective involvement of the SSI is at regional level.

There is general concern at the length of time taken between the end of the visit and publication of the report which averages about five months. The time consuming elements have been the typing of successive drafts from the team and editors, editorial checks, circulating the draft for comment and printing. The installation of a mini-computer at HAS HQ is intended to speed up the process and, in addition, teams will now take more responsibility for their report, thus cutting some of the editorial load from the secretariat. It is expected that these moves should reduce the time taken to about four months.

(6) Mechanisms for handling reports

Since HAS reports were made public in 1985 one of the tasks of DHAs and SSDs has been to set a date for publication, prepare press releases and hold a press conference. Some authorities have regarded this as a critical public relations exercise which, if well handled, could help to ensure press coverage was fair. Publication of the report requires authorities to prepare their response to the criticisms and advice for public debate.

The internal processes for dealing with HAS reports are determined by senior management in health districts and SSDs, and have no common pattern. In part they reflect the organisational structure of the agency. If the client group concerned is served by a discrete unit of management, as might be the case with a unit for mental illness or community services, responsibility for co-ordinating action on the report can be readily delegated to the relevant UGM, or, pre-Griffiths, delegated to the UMT. In SSDs a centrally based professional adviser or development officer for the elderly or mental health represents an appropriate focal point for progressing the recommendations. However, the organisational structure may not match the client groups served by HAS, in which case responsibility may be delegated to roles with a wider concern, such as Director of Planning or Patient Services Officer, or be diffused between roles.

The nature of the evaluation further helps determine how it is processed. Where serious criticisms of sub-standard provision or criticisms likely to provoke public scandal are made, immediate initiatives from senior management are stimulated. If the general tenor of the evaluation is critical, senior officers make an early start in considering the recommendations, in order to get their defences prepared.

At some stage members of health authorities and social service committees are brought in. Some members will have attended the opening meeting of the visit and also the final feedback meeting. But issues cannot be opened up at these events. To help them grasp the substance of the evaluation, officers provide members with a report of the issues raised at the feedback meeting. When the HAS report is published, copies are made available to members, although not always individually provided to them, accompanied by a report from senior officers. This commonly notes the major recommendations, indicates the officers' response to them and specific areas where urgent action is required. In some cases the report to members itemises each recommendation and indicates the extent to which it is being implemented.

Although the HAS report is likely to be noted by members rather than discussed in detail, they may be advised to set up their own mechanisms for overseeing further action. A Members' Panel may be instructed to review implementation and make periodic reports to the Authority. A Steering Committee of members and officers may be created for a similar purpose. In the NHS, authority members will be asked to approve the six-monthly progress report, before this is sent to HAS. This, too, is likely to itemise action taken on each recommendation.

Other staff and groups are involved in digesting and implementing the report, both formally and informally. Formally, working groups of interested parties, possibly drawing their membership from different agencies, consider recommendations or particular aspects, reporting back to senior management and/or to Authorities. Shortly after the visit or at the time of publication of the report, HAS appears on the agenda of relevant meetings in the health district and SSD. For example, HAS findings might be discussed by sub-groups of the JCC, at a consultant staff meeting, by area team meetings in SSDs, by the CHC and the FPC. We encountered an example of joint working arrangements between health and social services being seen to be revitalised because of the task of reviewing HAS recommendations.

Less formally, recommendations are circulated to senior practitioners and heads of relevant departments, for consideration and perhaps written comment. This involvement may result from participation by a key individual in the visit who notes the recommendations verbatim at the feedback meeting, or may stem from the circulation of a summary report, the HAS draft report or the final published report. Involvement is haphazard, depending upon whom the officer or officers co-ordinating action feel need to know, and on individual initiative in seeking information. In general we found that HAS reports are not seen as easy reading and are not widely read by those who do not have to do so, even when their existence is advertised and brought to staff attention.

Generally HAS reports appear to leave many ad hoc discussions and meetings bubbling in their wake. Practice varies as to how the reports are used internally; respondents felt that their use was conditioned by their content. Seniors used discretion in deciding what items to raise with their juniors and how they should be raised. Criticisms, it was suggested by those visited, should be discussed quickly to counter anger or falling morale. Recommendations dealing with management and policy would not be discussed with service providers, because such recommendations would have no direct relevance to their work. But there were examples of a UGM, or previously a Unit Administrator, holding open meetings with staff to discuss a HAS report or its follow-up.

Recommendations were likely to be taken more seriously by those who had most to gain. It was also the case that HAS generally received most attention from the less-prominent service professions, such as nursing, the therapies and clinical psychology. We also encountered examples of HAS reports being explicitly used for in-service training. Their value was said to lie in the broad vision of service development and its problems which they provided;

but there were dangers if they were treated as a blueprint for change.

HAS reports were used by officers, and by Authority members, to monitor progress, but as one mechanism among many. This was the case with regions which received copies of draft and published HAS reports. Regional officers attended HAS feedback meetings when teams reported their conclusions, and in some cases they participated in working parties set up to review recommendations. Copies of reports were available to members of Regional Authorities and their content was reported to members by officers. Information from HAS reports was used by regional officers in monitoring district progress. It might thus be taken up by a regional officer in discussion with his or her professional counterpart in a district. Indeed, regions appeared to be strengthening their use of HAS. At least one region had established a procedure whereby, following a HAS visit and report, its districts provided it with an implementation programme and note of any disagreements. The HAS evaluation was not, however, likely to be used explicitly by regions in a District Review, although it might provide part of the background knowledge that shaped the Review. Interestingly, SSD respondents saw HAS reports as being rather more explicitly and unambiguously taken up by SSIs in relation to SSDs.

Finally, a point can be made on the time scale for implementation. Where recommendations were straightforward, that is where they were uncontested, not dependent upon additional resources, new plans, policies or inter-agency agreements, implementation continued from the visit rather than waiting upon the published report. The oral HAS feedback and/or the draft report were treated as the final report. One estimate was that by the time the report was actually published, three to six months after the visit, local action was underway on two thirds of the detail. Also, as mentioned above, rapid local action may be motivated by HAS criticisms likely to involve media attention and public censure, and by the need to prepare a defence.

Recommendations that are controversial, and thus need negotiation, or that call for new ways of working and additional resources, require a longer time scale. They, too, will benefit from the presence of the published report as a support. Publication is also likely to be important for stimulating the voluntary bodies, whose involvement in the earlier stages of the evaluation process is marginal, to examine their services and their relationship with the statutory agencies.

(7) HAS/SSI Working

Once the Hospital Advisory Service became the Health Advisory Service in 1976 and incorporated community services in its terms of reference, the logic of including the personal social services in its remit was inescapable even if the mechanism through which this should be done was less obvious. That chosen was collaboration between the HAS and the (then) Social Work Service to form 'joint multi-disciplinary teams who can review together in a comprehensive way the complementary services provided in an area by the health service and by the social services departments of the local authorities'. (DHSS, 1976). Institutional tensions and anomalies were bound to arise. HAS was an independent service; the Social Work Service was part of the DHSS. The difficulties could have been expected to increase when the Social Work Service was converted into the SSI, but, as we have seen, SSI incorporates as much ambivalence about the functions of inspection and advice as does HAS.

Although permanent staff in the SSI rarely participate in HAS visits, the arrangements for the appointment of temporary SSIs to HAS teams described earlier demonstrate a relationship between them and the SSI that falls far short of the independence so highly prized by HAS. SSI members of HAS teams are accountable to the Assistant Chief Inspector in the Regional Office of SSI; their continuing employment in HAS teams depends on feedback from this same regional office and it is usual for them to have contact with the region during the visit, for example, to check the advisability of specific recommendations that might be contentious or have political implications. Moreover, before the visit begins, they establish a relationship with the SSD without the other team members. SSI members are introduced to the Department by the liaison inspector for the region. The disclaimer from the SSI that 'it is not intended to start the visit' at this point cannot alter the fact that a key part of the process through which visits work has got underway.

The SSI is also debriefed by the region after the visit 'to assist in the implementation process'. And region sometimes produces an SSI overview of a whole county's social services in relation to a whole series of HAS visits in a county.

It is difficult to avoid the conclusion that SSI team members become part of a network incorporating the SSI and the SSD of which other HAS team members are not a part. The separateness of this system is reinforced by the arrangements for conveying information about the SSD for the visit. This is the responsibility of the SSI and, often in practice, the information is received before the

visit only by the SSI member, so that it is not part of the preparation made by other team members.

The HAS directorate is aware of the need to counteract the potential isolation of SSI members from the rest of the team. The HAS memorandum to team members (1987) specifically emphasises that the 'SSI member should never be left to visit social services staff or facilities alone'. Our interviews suggested that in practice they sometimes are or alternately they might often be paired with the therapist member to undertake such tasks. The evidence from our observation of visits is mixed. In the main visits we observed there was strong participation by SSI in the health service visits and by other members of the team to the SSD. However, in one of the follow up visits the SSI went alone to the SSD. Follow up procedures in general are under review.

We received strong evidence from our interviews that teams often found it difficult to integrate the SSI members. The most serious problem identified was that SSI members were reluctant to criticise SSDs. Occasionally they seemed compelled into the role of advocate or defender of the social services. The structural factors outlined almost certainly contribute to the problem. Differences of conceptual systems and professional identity may also be important. SSI members are inevitably oriented towards the development and maintenance of community services or at any rate services outside the hospital setting. Our observation further suggests that they may be more sympathetic to pluralist models of service development entailing community group participation than their fellow team members. At the same time, they may be less sympathetic to developments initiated by health professionals, particularly doctors. Their professional identity may be less clear than that of other members. Temporary SSIs may be active or retired managers of the social services or they may be practice oriented professionals primarily concerned with the care and rights of client groups.

The problems of integrating health and social services personnel in teams may have serious implications for teams' capacities to model multi-disciplinarity and to conceptualise services in a way that is not narrowly limited by institutional boundaries. But there are larger policy problems. The SSI is seeking to play a more effective role in the development of personal social services and in the standards achieved across the country. Its resources for this task are limited and it may be tempted to concentrate them on work over which it has more effective control. If, as a statutory body, part of the DHSS, it continues to be marginalised in the workings of a small independent service such as HAS, it may lose interest. The point becomes sharper

as pressures for the enhancement of community care increase and social services become more important to elderly people and people with mental illness. If the community is seen as the pivot of service development, the claims of primacy by the health service become weaker. The current arrangements for collaboration between SSI and the HAS may no longer be regarded as viable.

5 Costs

The HAS carries out a large number of visits and produces general reports on its areas of concern. To produce between 40 and 50 main reports and a similar number of follow-up reports is a substantial publishing achievement in itself. It might be fairly said that it does so on a shoestring with a small headquarters' staff, compared with, for example, its Scottish counterpart. For its essential functions it depends upon operating on the margin of the NHS economy inasmuch as many team members – some 200 in each year – are released for at most a few weeks at a time. Employing authorities are fully reimbursed for the salaries of team members during the period of secondment, although in hardly any case will a substitute be employed. The large numbers of members of teams who are retired receive fees. SSI members of teams are appointed ad hoc, on temporary contracts, by the DHSS for that purpose.

As far as the HAS headquarters are concerned, the total estimated salary costs (1987/88) were just under £200,000. The total cost including administration of the separately organised drug advisory service is a little above £1 million made up as follows:

Table 6 HAS costs – 1987/1988

HAS headquarters manpower		199,250
Report production		8,370
Report distribution		60
Team member salaries:	HAS (main)	386,050
	HAS (follow up)	30,150
	DAS	43,400
Travel and subsistence (teams)		314,100
Travel and subsistence (staff)		21,450
Seminars		3,540
Telephones		4,800
Stationery/office machines		6,750
Postal charges		3,000
Total		1,020,920

The DHSS have reduced the HQ budget to £161,000 for 1988/89 as an economy measure.

From our observation, provision for the service is anything but lavish. Members of the teams are accommodated at normal public

service rates of travel and subsistence. Their activities are not underpinned by a vast and well equipped secretariat and, until recently, they lacked access to more modern methods for producing reports.

We do not know what cost to the DHSS arises from processing and treating the reports received by the HAS; we assume them to be subsumed in the Department's more general administration of the NHS and social services. We have seen, however, a careful analysis produced by the SSI (May 1987) which expresses some discontent with the efficacy of their own procedures and notes that more resources should be devoted to it. Between January and October 1986, a total of 281 sessions were used by the regions for HAS related work. Considerable SSI resources at headquarters were also thought to be devoted to the work. If savings can be achieved, the report says, by improving administrative arrangements this would probably be more than compensated for by an increase in policy work, in follow up activity and in promotional work.

As far as those visited are concerned, none could give a costed-out account of the visit. Those who commented, however, said that the direct costs were relatively trivial. They included minimal costs of entertaining visitors, 'we don't wine and dine them', and the cost of reproducing documents. The indirect costs were mainly opportunity costs. Thus one administrator had to delay his preparation of a new catering system in order to direct the preparation of the visit. One senior social services administrator stated that the time spent in preparing for the visit occupied some six hours. Visits were seen, however, to impose heavy burdens on work loads by some of the service practitioners.

Some senior managerial time is absorbed in dealing with the events which may surround publication. Work on follow up of the report's recommendations, however, might rightly be considered as a particular form of health and social service authority self-monitoring. This is part of the normal managerial task.

In all, the HAS is an economic service whose efficacy might be improved by marginal additions to costs of data scrutiny and on report production. If, however, more radical proposals for changes involving the creation of a larger core of professional staff are followed, costs would obviously rise substantially.

6 The impact of HAS

Any impact achieved by HAS in questioning, changing or confirming policies and practices results from the total process of preparation for, and participation in, the visit and not merely from the report; it is the cumulative impact of this total process that is considered here. But in attempting to assess impact we encountered familiar difficulties. It is hard to disentangle the effects of HAS from other influences: from already agreed programmes, from other policy initiatives and from the personal motivations and actions of those in post. It is rare to find changes that can be directly or unambiguously attributed to HAS and hard to assess the degree of change. Much of the change achieved by HAS is indirect: for example, a report might lead individuals to reassess their own attitudes, (although the results should be ultimately reflected in new ways of working), or HAS recommendations may confirm and strengthen an existing commitment or strategy.

Throughout our study respondents, from all disciplines and all agencies, were pessimistic in their expectations of HAS as a change agent. Yet scepticism was often misplaced. Evaluations were obviously taken seriously, by individuals and collectively by the agencies involved, although perhaps more so by health services than by SSDs. Most of the districts we studied, and groups within them, were clearly open to advice. At the minimum HAS focused attention on the service being evaluated and the reports provided a useful source of reference or check list of what might already be in train. Many, too, saw a visit as useful in stimulating individuals or disciplinary groups to assess and evaluate their own work. Some respondents accepted that evaluations could prove more influential; in clarifying different viewpoints and indicating gaps in provision and possibly the need for redirection.

It was widely agreed that HAS visits, focussing on services for priority groups, stimulated discussion about the balance of resources between them and acute services. More tangible outcomes of HAS visits included allocation of additional resources to the service visited, changes or increases in staffing allocations, new procedures and organisational arrangements and better connections, more immediately at the operational level, between parts of one authority or between health and social service authorities.

For the health services in particular, the HAS process encouraged authorities to achieve change, although HAS did not become directly

involved in the actual change process. The succession of activities – feedback meetings, circulation of the draft report, release and publication of the final report, six-monthly progress report, two and a half-yearly follow-up visit, release and publication of the follow-up report – provided a series of prompts to action.

It was therefore apparent from our case studies that changes did occur as recommended by HAS although we would not confidently link particular causes and effects. In seven of our eight studies where it was possible to make quantitative assessments of impact (either at the six-monthly report stage or in a follow-up visit at the time the report was received) over 50% of the recommendations were judged by the health authorities concerned as already implemented or intended to be implemented when circumstances allowed. (The range across the seven studies was from 52% to 92%). These figures, however, tell nothing of the quality or process of implementation. And it appears that it is particular types of recommendation, either related to glaring faults, or that are uncontentious, or directed at individual or group attitudes and behaviour rather than service policy, or that make little demand on resources, that are likely to be implemented quickly. Nonetheless, the comparison suggests that HAS evaluations do indeed have some impact.

Types of change

In none of our eight case studies were the effects of the evaluation marked by cataclysmic change or abrupt action. It was suggested to us that a HAS report would only have this impact if a service were a shambles. In such cases, thankfully rare, opposition would be overcome and the necessary resources made available. The effects as we observed them were percolative, providing an agenda for discussion, an 'aide memoire', encouraging further thought. Many reports expressed the need for changes in attitude and where the recommenda- tions were in tune with local thinking and attracted local champions, attitudes and changes would begin to percolate. Again, some recommendations remained inert and had no effects on service provision.

For the most part, recommendations did not lead to comprehensive and integrated change, which would stress inter-relationships and the application of a coherent service model. They were treated individually with the stress on tackling what appeared to be realistic and uncontentious.

The depth of change resulting from HAS visits also varied widely.

We noted some 'going through the motions' and giving attention to the recommendations without seeking to have them implemented. One authority in our study had, in the past, followed an HAS report in detail and found the results unhelpful. For the most part, however, authorities have made changes at the margin, attended to damage limitation; working on some of the specific recommendations, such as increasing staffing or up-grading facilities, without taking up those that question the philosophy or organisation of service provision.

Conditions affecting impact

Our case studies suggest a range of factors that affect the impact of HAS evaluations. An HAS evaluation is dynamic; it interacts with other influences in the service environment possibly spreading over years. Within this context the various affecting factors are themselves dynamic, influencing and being influenced by each other and thereby continually altering the context of the evaluation in which they operate.

Local perceptions and characteristics

The impact of an HAS evaluation is greater where recommendations reinforce local policy or policy that is desired locally. The report then finds champions and is used opportunistically to press for additional resources. One SSD was able to gain an addition to resources on the basis of an HAS report. In other authorities, too, cases that had already been mounted for additional resources or change in organisational patterns were reinforced and acted on. The effect of local support obviously depends upon which interests support the recommendations, whether there are opposing interests and the respective power of those involved. We have noted cases where local management sees the recommendations as a way of influencing service providers, or where some providers seek to use them to change the practice of other professional groups. Professional groups, too, use recommendations to influence managerial practice and organisational structures. In some cases, opposition rather than lack of support can reduce impact.

In the health service medical reactions have traditionally been crucial but, with the introduction of general management, managerial interests have become more influential. In one of our case studies, opposition by senior managers resulted in rejection of the principal recommendations. In two other studies, hostility to the

recommendations by the consultant staff was seen as posing a formidable obstacle to implementation.

A second issue is whether the recommendations are seen as realistic. Some of our respondents saw it as the role of HAS to advise how to provide the best. Others applauded the virtue of promoting the ideal but felt that promoting it would usually prove its own reward and that the ideal had to be tempered by what seemed possible. Yet others argued that promoting one ideal approach to a service was generally incorrect and unproductive. Recommendations seen as realistic were more likely to attract local support.

Expectations of the evaluation influenced responses. Staff have their own expectations and from our research these condition their later reactions. And authorities who expected a formative, advisory evaluation reacted critically to one that followed a summative, inspectorial mode, and vice versa. Service practitioners expecting help with details of provision criticised an evaluation that concentrated on planning and policy issues. In one case managers who expected an appraisal of services provided did not expect or accept a critique of their planning system. In two others, managers hoped for a critique of planning and were not impressed by a report with strong emphasis on service provision. Social services generally appeared less likely to regard HAS as a major service evaluation. At the same time, as an external evaluative body HAS attracted the 'Messiah Syndrome' and was frequently seen as the source of answers to all problems. This was particularly the case where local problems appeared intractable, and services were characterised by warring philosophies.

Knowledge of HAS was generally low except at the senior managerial and practitioner levels. Staff expectations of the process were likely to be unclear and unreal. We found that the experience and mythology of previous HAS visits cast a long shadow.

Territorial focus is a problem for HAS. Some social service departments in particular have a county-wide focus that is not addressed by evaluating individual health districts. The health authorities are frequently involved in multi-district planning strategies that cannot be fully appreciated by examining districts in isolation. If the major territorial focus of the service is disregarded in the evaluation, its value for policy and planning purposes is reduced. HAS visiting programmes are drawn up to ensure that, in most cases, where there is a series of health authorities relating to one social services authority, the health authorities are visited in sequence. A special report can then be produced for the social services authority which draws the relevant recommendations together. HAS also tries to ensure that teams have some members in common although this is

difficult because of time constraints. Separate teams working on different districts may vary in focus and their reports are more difficult to collate.

HAS interaction with local management and/or local practitioners is a critical factor, since the process of the visit may well be more important than the final Report in stimulating change. This is particularly the case if the evaluation strategy is formative. Team members have to gauge the balance between collegial, conflictual or educative strategies in promoting change. From our observation, teams did not give much explicit attention to the nature of their evaluation, whether it was summative or formative or the type of formative evaluation. But our case studies demonstrated the importance of the working climate set between HAS and the health district/social services department visited. The processes of engagement were particularly significant and, in our experience, relatively neglected. Impact was stronger where the HAS team carried local staff with them and prepared the ground for their recommendations. This is enjoined in the HAS Memorandum for Team Members but we encountered examples where the final HAS recommendations came as a surprise. Sometimes follow-up visits provided an opportunity for HAS team members to undertake developmental work associated with the original evaluation, although this was not their ostensible purpose.

The professional credibility of team members was also important. In almost all of our eight case studies, perceptions of the visitors' competence varied among the different groups who met them. However, one follow-up visit was particularly appreciated. The relevant case study reads:

> 'People from both authorities were surprised and impressed by the team's grasp of the district and of the issues ... Officers felt they had had the opportunity to contribute to meetings: these had been systematic in covering the ground and the monitoring element had not obscured current issues. People found the team courteous, thoughtful, interested, approachable, knowledgeable .... well briefed and able to listen .... A consultant who had been concerned that there was no medical member on the team felt that the administrator had thoroughly grasped his position and could help by reinforcing his plans.'

Many individual visitors were identified as helpful and knowledgeable. In a few cases, practitioner members of the team were felt to be insufficiently experienced or, because retired, not conversant with the most recent trends, or too assertive of a particular point of view.

Some were thought unable to appreciate a milieu different from that in which they themselves worked, for example, urban as against rural. In general, however, the case studies suggest that when the HAS lost credibility it was not through lack of professional competence, but through the absence of explicit criteria for evaluation, failure to accommodate the recently adopted doctrine of general management or, in one case, conflict within a team.

The nature of the recommendations

The reactions of the authorities visited to particular aspects of the reports were inevitably coloured by the general acceptability of the reports' findings. Misinterpretations of statistical detail, for example, could be presented as a large issue if the report as a whole did not find favour.

Recommendations already being promoted by management or by professionals or by particular interest groups were obviously more likely to be implemented. The support of the relevant UGM emerged as particularly significant in current health service structures.

The extent to which priorities were made clear by HAS teams was another consideration affecting impact. A common criticism was that its failure to indicate the priorities in its reports reduced its value to policy makers. The HAS *Memorandum for Team Members* (1987) suggests that priorities should be indicated by use of language – 'might', 'may', 'should', 'must'. Such differentiations may be too subtle and difficult to decode.

For the most part, HAS had greatest impact when it was encouraging and positive. The policy of publishing reports made it more difficult for HAS critique to have a positive impact. Criticism created defensiveness and likely rejection of the recommendations. And where, despite checking at the draft stage, reports were published with what were perceived as inaccuracies, HAS lost credibility. This does not, of course, dispose of the virtues of publication.

Considerations affecting the implementation process

Our evidence suggests that HAS was most influential in encouraging change when it was most visible, which was at the time of the visit. It then lost visibility, obscured by fresh situations and demands, although the draft report, published report and six-monthly progress report did offer continuing foci for attention. Significant changes were seen as requiring time. They had to be personally assimilated as

well as negotiated between the various interests involved. In one case at least, recommendations were received negatively but many were acted upon after a period of reflection.

The clear allocation of responsibility for implementation was suggested as crucial in explaining why some evaluations appeared to generate change and others did not. The HAS Memorandum (1987) states that each item of advice should indicate the individual or body responsible for its implementation. But HAS understandings of responsibility, even if explicit, did not necessarily accord with service decisions which, in some cases, were not determined until long after the visit had been received. The role made responsible depended on the target of the evaluation. For example in the health service, advice on service delivery required a management role that was familiar with service detail, such as a UGM. An evaluation focused on policy and planning required a senior district management role that was familiar with the regional/district policy setting context, such as a Director of Planning. The advent of general management in the NHS had proved beneficial in locating responsibility for securing change more certainly than hitherto. As far as HAS was concerned, this prevented recommendations becoming lost in the system, 'kicked around among too many groups', although managerial interests had been strengthened in the process. It was suggested that action taken in respect of HAS recommendations might be one element in managerial performance appraisals. Many respondents suggested that since HAS was in the business of generating change, it was nonsensical that it did not follow the process through and become directly involved.

The visibility of recommendations relates to their nature and support by local interests. We found that service managers could promote and maintain visibility by the processes they devised for dealing with HAS. Similarly, particular service interest groups, such as professional disciplines, could ensure that recommendations remained as live issues. But equally, visibility could be diverted by the emergence of new issues or by disinterest among service practitioners. Publication of reports was seen as alerting external interests and stimulating their participation but in our experience this was more an expectation, or perhaps a fear, than a reality. The influence of publication depended upon the extent of local media interest and in most cases this proved slight. Of the four studies undertaken where the reports were published, the local press took a more than passing interest only in two. And in only one case was the health authority seen as having been slated by the press.

Contextual considerations

We have emphasised throughout that the HAS visiting process does not stand alone. The health and social service authorities have already determined their local priorities and it must follow that HAS evaluations are likely to have a feeble impact if they do not to some extent match with local perceptions of needs. The organisational milieu of the authorities is also critical. In particular, recurrent reorganisation has reduced the energy available for other changes including those that might be advised by HAS.

Again, whilst evaluators might reasonably argue that it is their task to point to defects and to open the way for improvement and that it is for others to concern themselves with the resource implications, HAS loses credibility in some cases because it is perceived to fail sufficiently to understand and address financial and other resource constraints. It is obviously important for HAS teams to be realistic in the advice they give. It is important not to ascribe problems too easily to inadequate finance. But if HAS are perceived as too constrained by current assumptions about resource allocation and availability, their value as an independent watchdog for priority group services could begin to be doubted in the providing authorities.

A further contextual consideration is the extent to which there is consensus on the philosophies of care, service delivery and general policy. In some cases we found deep divisions between those advocating the merits of institutional and community based approaches to care. There were also cases where the elderly were treated according to one pattern of care and the elderly severely mentally infirm according to another. The presence of serious disagreements spilled over into reactions to HAS recommendations and made their implementation harder.

Summation

The impacts of HAS evaluations are strongly affected by all of the contextual factors to which we have referred and are often diffuse, indirect and difficult to generalise. With these reservations in mind, we summarise the impacts discernible from our eight case studies as follows. We also represent them in diagrammatic form in Table 7.

The system of visits ensures minimum standards. It is widely known that these health and social services are subject to external appraisal and public report. Even when issues of minimum standards need not arise, in almost all of our case studies it was noted that the visit meant that a priority group received attention for a concentrated

Table 7 – Summary of impact of HAS on visited authorities

Type of HAS Activity	*Nature and impact or types of response*	*Extent of impact in the case studies*
1. *Notification of visit:*	*Administrative response:* collating information	Large
Request for information	*Operational responses:* focus on priority group:	
Outline of aims	Intra-professional preparation/appraisal; identifying issues	Some
	Policy/strategic responses:	
	Setting goals for visit	Small
	Internal briefing	Some
	Co-ordinating approaches	Small
2. *Intra-professional meetings:*		
Eliciting views and information on services and practice;	Reappraisal or hardening of beliefs	Some
Checking information;	Reappraisal or hardening of beliefs	Some
Identifying needs;	Reappraisal or hardening of beliefs	Some
Challenging approaches and attitudes	New thinking; reappraisal or hardening of beliefs	Some
Support/encouragement;	Morale strengthened/beliefs hardened	Large
Direct advice	Reappraisal or hardening of beliefs	Some
3. *Inter-professional; Inter-disciplinary; Inter-organisational meetings*		
Eliciting views and information on services and practice	Reappraisal or hardening of beliefs	Some
Checking information	Reappraisal or hardening of beliefs	Some
Identifying needs	Reappraisal or hardening of beliefs	Some

Type of HAS Activity	*Nature and impact or types of response*	*Extent of impact in the case studies*
Challenging approaches and attitudes	Reappraisal or hardening of beliefs	Small
Support/encouragement	Morale strengthened/beliefs hardened	Some
Direct advice	Reappraisal of hardening of beliefs	Some
Stimulating communication	New structures changing attitudes in working relationships	Small
Cross-checking information and perceptions	New structures changing attitudes in working relationships	Some
4. *Meetings with managers and professional leaders:*		
Review of services	Reappraisal or reaffirmation of policies and plans	Small
Discussion of plans for service developments	Reappraisal and change or modification of procedures and structures	Some/small
5. *Site visits:*		
Observing practice; checking information; obtaining views; observing physical environment	Changing practice and patient care; liaison	Some/large
	Increasing resource for physical environment and staffing	Some/large
6. *Report:*		
Articulating/setting standards	Used for monitoring and review	Small
Assessment of services/planning/policies/ environment	Operational changes (administrative, procedural)	Some/small
Identifying changes required in services	Used for monitoring and review, change in resource priorities	Small
Identifying changes required in outcome	New plans, new implementation structures	Small

period of time. The structure of the HAS schedule ensures further concentrated attention in the events following the visit itself.

Impact might occur at the strategic planning, the operational management and the patient service level. As far as the patient service level is concerned, all of the HAS visits had some effect through their visits to particular sites. They led to improvements in patient environments and changes in ward level practice. In two cases at least, they led, too, to changes in management structures and in the allocation and numbers of staff. These changes may not seem significant in terms of macro-planning or major shifts in professional assumptions. But they are important to the patients and staff concerned at the working level of the services.

For the most part, changes at the strategic level did not result from the eight visits. Large scale changes in management and organisation, planning systems, allocation of resources, or wholesale changes in professional practice did not occur. HAS gave impetus to changes already in train. Also, it must be noted that our sample did not include visits triggered off by serious deficiencies brought to political attention.

In addition to these three major categories of potential impact, other effects could be noted, although not across the board. Meetings within professions take place as part of HAS visits. They require those participating to engage in some appraisal of their work. This in its turn may lead either to new thinking and to reappraisal, or to hardening of beliefs. Within professional groups morale might be strengthened, particularly in the case of the less privileged professional groups. Some new initiatives across professional and agency boundaries were also noted: new arrangements for liaison or co-ordination and forums for discussion.

If we look for direct impact of the HAS report we must note that it was used to small effect for monitoring and review although some groups used it for in-service training purposes which might itself lead to a review of practice.

In reaching these summative conclusions, we ought to add that in our view no advisory services in the areas of education, health or personal social services are likely to produce stronger impacts than those denoted here; services that exercise explicit inspectorial authority, however, do have more direct effects.

7 HAS and the national policy system

The wider purposes of HAS are declared to include (HC(84)16):

- keeping government aware of the outcome of service provision for the client groups concerned;
- identifying areas of difficulty in the provision of services, especially those which may require policy changes.

These purposes imply a continuing relationship between HAS and central government. The nature of this relationship forms the subject of this Chapter, which is concerned with the HAS and that part of the DHSS that is concerned with health policy and service, and the HAS and SSI connection. The terms of reference of our study, however, invited us to concentrate on the impact of HAS on health and social service authorities. Although we sketch in here, as part of context, the relationship of HAS to central authorities, we were not able to make an equivalent study of them.

The relation of the SSI to the HAS is different from that of the health side of the DHSS in two ways. First, SSIs (although usually of temporary status) participate as individual members of HAS teams, whereas DHSS officers do not. Does SSI participation compromise the independence of HAS? Second, the DHSS is at the apex of a direct line of command to health authorities but this is not the case in respect of SSIs and social services departments, which are a local government responsibility. Do weaker central structures reduce the impact of HAS with SSDs?

HAS and the DHSS

Use of reports

Research Liaison Division (RLD) of the DHSS receives copies of HAS reports when they are sent to the Secretary of State. They are then distributed to the relevant client group team, elderly or mental health, for review. In reviewing individual reports there are a number of purposes:

(a) to see that HAS recommendations accord with national policies. Lack of financial realism is not regarded as a failure to accord with national policies but it is a problem for the DHSS;

(b) to check that there are no matters that require immediate ministerial action. Clearly ministers must be informed if HAS have exposed conditions that will result in a public scandal when the report is published;

(c) to provide general information regarding health and social services that can be used to answer ministerial queries and as briefing material for ministerial visits;

(d) to provide the DHSS with insights into the condition of services and the application of national policies. Officers use the reports for building up pictures of different aspects of service provision but their input into policy-making is indirect. Reports are too specific and too detailed to be generalised for policy-making. Something shorter, more strategically orientated and providing clear assessments of local services would be of greater use. By contrast, the annual HAS reports were seen as influencing policy making. They are more general and strategic and the DHSS is likely to consider their content in providing a brief for ministers.

Influence on policy

These insights gained from HAS reports are applied to policy making in a number of ways.

They may flag issues that should be taken up in Regional Reviews. It is likely that perceptions gained from HAS are already known from other contacts but they add to the DHSS's overall perceptions of regional performance. It is likely that any explicit reference to HAS would be taken up in preliminary discussions rather than figure on the agenda of the Review. It is, of course, for the regions to follow up issues raised by HAS with their own districts. If they fail to do so and the issues involved are seen as significant and involving national policies, the RLD may discuss the implementation of the recommendations with the district concerned. This, however, is a rare occurrence (only one example was cited).

Officers also use insights gained from HAS in their own professional networks.

Rarely, regions and districts can appeal against unpopular HAS recommendations to the DHSS. In responding, the DHSS is providing a view, not a binding decision. It is up to the authorities concerned to decide their own response to HAS.

Visits and team membership

HAS informs client groups, via RLD, of its proposed programme of visits. This provides the DHSS with an opportunity to supply information on the district services, that officials feel it would be useful for HAS to know. In fact, information is rarely supplied. Officials do not see it as appropriate for the DHSS to initiate visits with HAS although they occasionally comment on programmes. The HAS is independent of the DHSS and must be seen to be so. If it was believed that a particular visit would be beneficial, it would be more appropriate to refer the matter to the region concerned and suggest that the region might care to initiate a visit with HAS. DHSS officials might, too, suggest names of suitable team members to HAS from their own professional contacts.

Contacts between HAS and DHSS

The HAS reports directly to Ministers although, inevitably, the main working link lies with the officials in the departments' client groups. Each year the HAS Director meets the two client group teams to discuss HAS experience and DHSS concerns. There is also an annual administrative meeting between HAS and the DHSS. Among other matters, the draft Annual Report is discussed.

HAS and the SSI

Use of reports

As partners and co-publishers with HAS, the SSI receive copies of all reports in draft form which they send to the appropriate regional office. This process alerts SSI to the tenor of the forthcoming report and the recommendations it contains, and enables SSIs to assess the HAS evaluation of the service in the light of their own knowledge and experience. The process also provides a safeguard that the recommendations made do not contradict national policy.

The reports themselves were seen to contain a great deal of information, much of it useful, but its actual application at the centre was felt to be slight. This was partly a function of the time required to gut reports of relevant information and partly because much of what the reports contained was already known to the inspectorate. It was certainly valuable for the inspectorate to have their insights and experiences confirmed but the annual HAS reports, which summarised and integrated HAS experience, were of more use than individual reports in this respect and certainly easier to handle.

The reports were seen to be of more use within the regional offices, where they did help develop better understanding of the health authorities by the regional inspectorate.

Influence on SSI policy thinking

HAS was not seen by SSI members interviewed as exerting a strong influence on national policy. The potential for the SSI to link HAS work with planning on the health side of the DHSS depended upon the interdisciplinary client groups. These were not seen as making much use of HAS evaluations, although members of the groups received HAS reports and worked through them. And there was the difficulty that organisationally the health and social services planning systems were only loosely connected.

There were reasons why the SSI would be wary of HAS reports playing a larger role in policy making. Their evaluations did not cover the policy concerns of social services. Consumer viewpoints were largely neglected, as were primary health care and prevention to which HAS had no right of entry, both of which were crucial areas for community care.

The value of HAS to SSI was not seen to be in its contribution to national policy making but rather in its ability to engender local change.

Visits and SSI team membership

SSI receives details of the proposed programme of HAS visits, and can suggest alternatives or reservations.

SSI headquarters asks regional offices to suggest suitable members of visits. Approximately 70% of social service team members are retired persons, whilst 30% are seconded from SSDs. SSI has considered whether there are advantages in seconding headquarters and regional SSIs to teams, to strengthen liaison and provide an opportunity for reaffirming policy. However, team membership by permanent SSIs, particularly those based at the DHSS, might infringe the autonomy of HAS of central government.

HAS and SSI work together in recruiting and allocating social service team members and through SSI membership of the inter-disciplinary client groups in the DHSS which meet once or twice a year with HAS. They meet at annual training seminars for team members but otherwise there are few opportunities for SSIs to meet the HAS Director and discuss their particular concerns and HAS arrangements.

SSI and HAS functions

Where the functions are similar, SSI is thought to have a similar approach to that of HAS. However, SSI has many functions beyond those of HAS which require it to act in a range of modes. In the present economic and political climate, for example, it is necessary to evaluate service management as well as service practice; this requires a different emphasis and team membership from that of HAS.

In principle HAS and SSI are partners in evaluation exercises. The reality is that HAS is primarily a *health* advisory service. The HAS work undertaken by SSI is considerable, yet it does not achieve much visibility within either the DHSS or the wider service community.

HAS and the professions

The professional institutions consulted for our study obtained all HAS reports on publication. Interviews with officers of the institutions indicated that the reports were seen as a useful source of information, especially in preparing for their visits to the field.

They may take up general issues and themes emerging from reports, and particularly from the Annual Report, with the DHSS. Views differed on whether reports contributed significantly to the creation of the institution's policy viewpoints.

Issues relating to specific districts may get taken up with appropriate members by the British Geriatric Society (BGS) although not by the Institute of Health Service Managers (IHSM) or the Royal College of Nursing (RCN).

Institutions may suggest team members either formally or informally to HAS. Team membership was seen as useful professional training. The IHMS had helped HAS by suggesting adaptations to the role of administrative team members as it developed into general management.

The institutions have occasional meetings with HAS. Contacts are closer in the case of the medical institutions, one of which at any time is likely to include the HAS Director as a member.

Discussions with members of the institutions suggested that HAS is seen as advisory, providing a catalyst for change. Its impact depends on its ability to convince individuals. Those bodies with the power to affect services immediately are seen as stronger. HAS is also seen as suffering from an ambiguity in the way in which it worked. Its membership increasingly reflects policy and managerial experience, while its programme is still directed towards service delivery. It was also suggested that HAS would benefit from becoming more involved in service development and change processes. It might then offer a consultancy on a commercial basis.

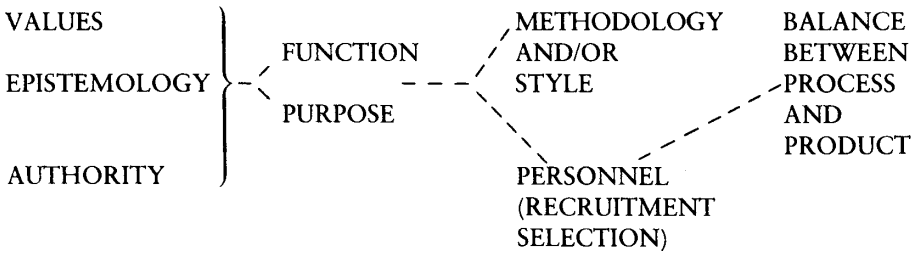
8 Evaluative models and the HAS

Underlying the modes of HAS visits are questions of the evaluative stance evinced in the work of the HAS. We shall suggest in this chapter that, while a clear model of evaluation can be discerned in HAS' formal presentations of its functions, the structures and processes laid down for implementing these functions are to some extent in conflict with it. And while HAS teams' perceptions of their role are broadly congruent with those of the HAS Directorate, views in the authorities are often seriously at variance with HAS perceptions.

HAS conception

The evaluative model implicit in the HAS conception of its function comprises a number of components. It might be represented as in Table 6.

Figure 4 – HAS evaluative model (components)



Guidance from the HAS directorate emphasises the purposes or functions of HAS, the style of evaluation to meet them and, implicitly, the nature of HAS' authority and the professional values that it represents. The epistemology that underpins its work is also implicit and linked with the status and knowledge of members assumed to be essential to its working.

The memorandum for team members (1987) makes it clear that HAS is an advisory service. Its purpose is to 'look at' services and advise those concerned with them on how they can build constructively on what they have. The idea is to help and a key means of helping is to enable districts to define their problems. The style is to

be collaborative and demonstrative of 'the values of respect and co-operation between disciplines' so as to 'facilitate discussion of the service providers' problems as if mutually shared'. The uniqueness of individual services is emphasised and, with it, the inappropriateness of offering 'standard' solutions. Criticism is to be meted out with care and effectively limited to services where morale is high.

While there is, in the report written for each authority, a clearly identifiable product of HAS visits, HAS visits set in motion a process, continued by those visited, who go on to develop their own products in their own unspecified time.

HAS evaluations are thus intended to be formative and harnessed to an overriding purpose of development or change.

The authority of HAS derived from its right to report directly to the Secretary of State is relatively underplayed. What is stressed is sapiential and status based authority. The wisdom implied is, in Rossi's terms, connoisseurial or grounded in experience (Rossi, 1982), rather than in scientific inquiry or expertise. Thus the knowledge base of HAS is primarily subjective, individually internalised knowledge demonstrated in action and marshalled in judgement. It resides in the people selected to the panel of visitors on criteria of professional distinction, broad experience and 'a proven aptitude for multi-disciplinary working'. (HAS, 1987) The values espoused are made more explicit in the debate conducted in the pages of the *Bulletin of the Royal College of Psychiatrists* (1986). There one of the challenges to the Director from psychiatrist critics of HAS was that HAS teams failed to demonstrate that their judgements were grounded in objective knowledge: research, externalised norms and comparative data. He defended them, again in part, by reference to their experience, which protected them from gullibility and ill-considered pronouncements, and made no apology for low priority given to research findings in their reports. Their prime concern was to evolve workable local solutions to local problems out of an interactive process. Here he was also defending them against a linked set of charges that they were proselytising stock HAS norms of service of unproven value, and applying them in a stereotyped way. HAS was essentially concerned not with generalisation but with flexibility and responsiveness.

Evaluative model and HAS structures and processes

Our description of the way in which HAS works suggests that the structure or frame within which visits are made is inconsistent with its underlying concepts and purposes. The main visit followed two

and a half years later by a follow up visit sets a pattern which more neatly fits a summative evaluation with a built in check on progress made and a direct impact model of change, rather than one of continuing development to which HAS can give periodic impetus or challenge. Within this second model a follow up visit nearer the main visit would better sustain the momentum which HAS is apparently designed to set in train. HAS' own view now is that it would be better to abolish follow up visits and aim to have full visits at four or five year intervals, instead of the current eight to ten year interval.

The set format of the report puts a premium on comprehensive coverage which fits in well with the expectation of a full inspection. It fits less well with the idea of an exercise geared towards an individualised focus and the identification of key points of change or with a set of services in a constant state of flux.

Teams in our study varied in the extent to which they tested out their developing perceptions with those most concerned in authorities during a visit. But all tried hard to conform to the requirement that at the end of a visit clear feedback is given and dialogue actively discouraged. This event, summative in form, can leave authorities with an impression that the exercise was primarily geared to the delivery of judgements. HAS has itself been concerned about this event. They are currently running an experiment in which the feedback meeting in alternate visits encourages response and discussion from the authorities.

A frequent criticism of reports is that they tell the authority nothing it has not worked out for itself. This is entirely consistent with a model of change in which the role of HAS is to stimulate action or to draw out and publicise views that have not been given due weight. It is not consistent with the format and style of the report and feedback which cut across the formative intention of evaluations. Staff who have honestly shared problems and weaknesses in their service are discouraged when these are set out in reports as if they were wholly external judgements. The problem has been exacerbated with the publication of reports. And publication in itself may be thought to be consistent with a coercive model of change.

HAS lays strong emphasis on the modelling by teams of multidisciplinary working. Teams are required to develop a common framework for helping authorities from different professional perspectives. Different perspectives and styles of evaluation were expected and accepted by teams. Sometimes these were dealt with by compartmentalising the recommendations; where that was not possible, members worked hard to secure agreement and resolve conflicts.

But the format of the reports was felt by many to reinforce their different disciplinary bases and draw attention to professional practice and organisation rather than to the integration of services and the experience of those services by patients and families.

In the next section we examine more closely the views of the team in our study. We consider their account of the values and knowledge they brought to their work, the authority they ascribed to the HAS and the purpose and style of evaluation they sought to put into practice.

HAS teams' perspectives: sources and nature of evaluative criteria

The source of evaluative criteria most frequently mentioned by team members in our study was their own experience. The importance of this was confirmed by our own observation of meetings in the visits we attended. Members spoke of using a blend of personal experience and personal and professional values. 'Evaluation depended ... on what individual members saw as important, and this varied from one to another'.

While a few people expressed doubts about such an approach, commenting, for example, that there was no agreement in the team about what they meant by 'good practice', others justified it. They felt that, provided they thought carefully about the individual circumstances they found in authorities, a flexible mix of personal experience and professional values together with service norms where these existed, could be tailored to specific problems. The danger would be in applying them rigidly. Others made stronger claims. These were that if senior people with acknowledged reputations were selected to teams the values they brought with them would be those accepted nationally by the profession.

For the most part values were implicit and not a matter of discussion amongst team members. The administrator who, in discussion with a staff group concerned with the elderly mentally infirm, explicitly set his own perspective based on patients' rights of access against a professional contention that a service should be made available only to those professionally assessed as able to benefit from it, was unusual. Similarly, the member who could readily state that her perspectives on services were held together by a belief in the right of all to retain the maximum possible control over their own lives was probably exceptional in the coherence and explicitness of her value position.

Norms and standards

These played a minor part in the visits selected for our study. The definition and basis of norms were not entirely clear. Members spoke of bed occupancy, length of stay and case loads as professional norms, but all are the subject of professional disagreement and in some cases such norms derive from central government pronouncements rather than statements of professional standards. Members claimed to apply norms where they existed, but there was no evidence of this happening on any systematic basis. In our observation, team members who identified deviation from a norm might find themselves challenged in the team and by the authority. Performance indicators were not part of the language of the HAS visits that we observed.

Some individual team members had developed their own check lists of indicators of quality of service provision or management. One stated that she based these on NHS guidelines about staffing establishments and arrangements for staff development and interdisciplinary collaboration. But for the most part they seemed to be based on members' own practice and experience of visits. Nowhere were they made explicit to the visited authority or indeed to other team members.

Models of provision and evaluative criteria

A minority of team members reported bringing specific models of service to their work on HAS visits. Those who did were most often doctors, nurses or new generation managers. Administrators were least likely to base their evaluation on models. Geriatricians seemed conscious of specific alternative models of service operated across the country. ('Integrated' and 'age-related' seemed the most recognised). They were, however, models of medical organisation rather than of whole services. Some nurse team members' approach was influenced by concepts of the nursing process or 'care packages'. Prominent members on two visits to mental health services based their approach on models of mental health services with which they were strongly identified in their own working lives. References to research were rare.

However, in at least two cases, the model espoused by influential members of the team had a profound effect on the visit and the report.

Planning and management models

Only one of the teams in our study was prepared to offer substantial help on multi-agency planning models or methodology, although at least two authorities were at a point of development where they would have liked this and one had specifically requested it.

One team was concerned about an authority's unit management structure. But no team members discussed the implications for their work of the shift to a general management structure. Multi-disciplinarity featured quite strongly in some reports. For the most part, however, no clear picture was given by teams of how this was to be realised or even what it meant.

HAS functions and authority

If teams broadly endorsed the HAS directorate's view about the epistemology and value base of HAS, their views of its functions and authority were more diverse.

For the most part, team members saw HAS as an advisory service, not an inspectorate. However, they meant by this a number of different things:–

- that HAS had no coercive power or sanctions, although some thought its mandate to report direct to the Secretary of State important; others felt that it had a 'moral' authority;
- that its role was actively educative (or even corrective): 'sometimes authorities have to be told that they are wrong'. (Interview) In the view of this respondent, teams had to move out of the listening, responsive role at some point in a visit into a didactic mode. They needed not only to formulate solutions appropriate to the authority but also to get its commitment to them, if at all possible. This was a strong version of a view held by a number of people; others stressed the function of disseminating good practice or introducing staff to new ideas;
- that HAS was primarily a catalyst. In some cases this was akin to the idea of evaluation as illumination: people might develop or change their services as a result of self reflection and greater awareness of the nature and implications of current approaches. Some respondents emphasised the value of interaction with the visitors, some that of giving a voice to those not usually heard in the service and some the importance of inter and intra-agency dialogue. Staff were brought face to face with others' perceptions of them. The objective might sometimes be to raise morale

or change people's feelings and attitudes; sometimes it was a matter of changing perception or thinking.

This latter set of perceptions demonstrates the relationship between evaluation and change. For some people concepts of change were dominant. Within this conceptual framework, too, there were wide differences. Some had essentially coercive models in their mind; others stressed the importance of interaction and education. Some stressed the importance of an external agent who could be perceived as a peer; some the power of intellectual or emotional impact; others thought in terms of systems. For them effective change required a holistic approach: structures in which change could be conceived and implemented.

If team members reflected diverse ideas about the function and style of HAS, they held more consistent views of its authority. Teams (like many respondents in authorities) felt that the status and credibility of the team were crucial. Some also stressed the importance of impartiality, an external perspective, even if these ideas were not linked to a concept of objective knowledge.

Some thought that there remained a residual inspectorial role: although they thought that times had changed and HAS did not have to keep an eye open for scandal to the same extent as in the beginning, it did help to maintain standards. It was needed as a watchdog on behalf of neglected groups, in the name of social justice. Alternatively it might be seen as carrying out an audit. As such it could at the same time be a tool for local managers.

One or two team members spoke of forces moving them towards an inspectorial or judgemental role against their will. One thought that demand was coming from general managers for assessment of their services, perhaps as an indicator of their own performance. This could support them when their contracts were under review. Alternatively it might be a function of the climate in which performance and objective measures were central. Another felt impelled into a judgemental stance from what seemed to be required in the role of HAS team member: a detached, listening mode, in which argument and debate were out of place, because a summative conclusion to the process was expected.

Perceptions in the authorities of HAS' evaluative models

How well were the teams' perspectives matched by those in the authorities visited? There were widely differing views in authorities of the evaluative model underpinning HAS and of how it worked in

practice. This section focuses primarily on respondents' accounts of their experience which was often coloured by their encounters with the team member from their own professional group. This was one explanation of the different perceptions of HAS reported by respondents in the same authority.

Evidence from those visited was largely in accord with that of the HAS and teams about the underlying epistemology and the sources of evaluative criteria. These were felt to be largely implicit, subjective and based on team members' own experience. For the most part, respondents appreciated team members drawing attention to good practices or approaches to problems that they had observed when visiting other authorities. Often they would have liked more input of this kind. Views on teams' professional authority varied. Nurses and therapists were more likely to concede this in the case of the team member from their professional group; doctors, managers and social workers were less likely to do so. In some cases, therefore, the argument that acceptable values were assured by team members' professional prestige was undermined by respondents. Respondents seemed to value a more general professional or systematic approach to visits, evinced in good preparation and a structured and active approach to visits. They appreciated members with a responsive and interactive style as much as and sometimes more than professional status. A doctor believed that a team which had no medical representative on it had understood his position well, while a nurse was critical of a team with a high status nurse who was perceived as imposing particular views of practice. However, a professional group who wished to use the HAS visit as a lever politically would have liked a team of perceptibly higher status.

Those visited were much more likely than team members themselves to perceive teams' style as reflecting an inspectorial function even if they did not believe that to be its role. Often they meant by inspectorial not so much an assessment against a set of external standards as a didactive or even coercive approach.

A minority of respondents favoured a coercive model of change, often people whose morale was low. For the most part respondents favoured an enabling model of change in which HAS acted as articulator, supporter and legitimator of latent or existent policies and plans.

Authorities' critiques could be said to fall crudely into three main categories:–

(1) those that wanted a body with clearer authority based either on teams with more widely acknowledged status or on more

explicit, more objective and more technical knowledge; general managers and consultants were most likely to take this stance (in the case of general managers, they wanted a new model);

(2) (sometimes linked with (1)): those challenging the basic HAS assumption that professionals hold the key to the development and maintenance of good services. They would advocate a shift to a more integrated form of evaluation. This would be managerial in style, and would incorporate the evaluation of service delivery within the context of resources;

(3) those that wanted the concept of HAS as a catalyst, giving impetus to a process in which authorities held the responsibility for choice and action, to be more widely and completely implemented. (More real commitment to the existing model).

9 Propositions and models for policy

Our findings are based on what we learned in our eight case study areas, and from our own interrogation of the logic underlying the HAS arrangements. In this chapter we summarise and attempt to apply them to current policy concerns.

Previous chapters contain criticisms of the HAS. It is common experience, however, that whilst criticisms are specific, supportive perceptions are likely to be general and diffused, and less likely to emerge from a summary of case studies. Our first finding is in any case that almost all in the field believe that there should be a Health Advisory Service and we noted many statements of appreciation of its work.

Our main propositions for policy and action divide into advice on procedures, on objectives and focus, and on evaluative models and authority.

Current working of HAS

1. The original Crossman objective, that the HAS would identify problems and advise the Secretary of State, has long been overlaid by other objectives which themselves need now to be clarified and perhaps given priority order. Changes of objectives and operation in the HAS have not all been matched by changes in the structures and processes within which it works.

Objectives

2. The formally stated objectives of the HAS are that it will be a multidisciplinary and peer review aimed at advice and at objective evaluation. The advice is to be directed at the needs of individual authorities and is to respond to their perceptions of the problems and to their solutions. Some authorities visited and teams visiting them experienced HAS as working in the manner described above and believed these to be the right objectives. Others felt that HAS lacked authority; others again thought the style of HAS teams inappropriately inspectorial, and their feedback prescriptive and fragmented.

3. These disparities may partly be explained by a mismatch between the stated objectives and some of the key characteristics of HAS as follows:

(a) the basic framework of the operation which is mandatory. Authorities are required to receive the visit, to submit reports of progress at defined intervals and to receive follow up visits;
(b) the structure of the programme created for the visits themselves;
(c) the structure of the team's report. It is discipline-based and geared towards comprehensive coverage of issues. The consequence is sometimes that reports fail to identify priorities or to attend to strategic issues or to consider how parts of the system are brought together to affect performance;
(d) the nature of the final feedback meeting which endorses the perception of an inspectorial process.

4. Our assessment of HAS's outputs are that they are not consistent with HAS's declared objectives. The visits do not provide an advisory and formative evaluation but rather a liberal summative evaluation which aims to be as comprehensive as it can be within the constraints of time, money and staffing arrangements. It emphasises operational rather than planning issues and is based on a multi-professional approach which members of teams try hard to make effective. That is, however, an approach which fits more comfortably with consensus management than with general management.

Impacts

5. At the beginning and in the concluding paragraphs of Chapter 6 we noted the extent to which HAS achieves impacts. Within authority areas, the impact is often important as far as services to patients are concerned. We have noted, however, no major example of impact on fundamental values or on a total system of organisation or planning or of resource allocation. Although it is most unlikely that inspectorial or advisory services ever make such large scale impacts, we believe that HAS could have more effect both at the operational and service levels and at the macro-levels.
6. Impact was more obvious when there was a local champion for the changes suggested. It would help if the report defined clearly the point from which action is needed and whose is the responsibility for taking further action. This would be an issue to be addressed and negotiated during the course of a visit.
7. The Special and Annual Reports of the HAS are valued. However, the intended dissemination of good practice in the services at large, by picking up conclusions from visit reports, through the Index of Good Practice and through other methods, did not emerge from our case studies as an important outcome of HAS work as perceived in

the field. The HAS generates important information whose potential could be better exploited. This would require a comprehensive and systematic analysis of materials which would require additional resources.

8. Taking into account these findings, we believe that HAS could be more effective if there were some structural and procedural changes, particularly towards a stronger focusing of function, and some shift in its objectives.

Structural and procedural changes

9. The preparation of visits could be given more attention and directed towards giving the exericise more focus in the following ways:–

(a) The Director's preliminary visit does much to clarify the agenda of issues, and is generally seen as indispensable. It can help counteract those authorities which evince weak insight or interest in their own services or wish to promote particular aspects without sufficient consideration or testing of alternatives or implications. But the Director's brief is substantially modified by the team's ideas of what is important, which, legitimately and inevitably, may not always correspond either to his or to the DHA's and SSD's agenda;

(b) before the visit of the Director, authorities could be required to be more disciplined in the choice and presentation of the data submitted to HAS. Both HAS and the authorities could then more readily identify priorities for the visit and attempt to reach shared perceptions of how the visit could best be structured to match the purposes. This would have the merit of helping to focus the visit but, just as important, to making the authorities active participants from the beginning. We accept that these proposals would extend the planning period before the visit and demand a degree of prior analysis by HAS staff but the advantages would be considerable;

(c) the team would then be better prepared, although still free to modify the focus of the visit once it began, as different views emerged from early contacts and from groups less well represented in the preparation stage.

Team membership

10. If the ground work described above could be completed early enough, it might then be possible to select teams more as horses for

courses although we recognise the difficulty of identifying and securing the services of those best fitted for particular missions. This brings us to the issue of whether the HAS should remain committed to the employment of a changing cast of players. It may be possible to undertake the preparatory analytic work only if a system of secondment lends some continuity to the professional expertise of HAS.

11. There would be difficulties in pursuing a system of secondment. Able people often cannot be spared. But secondment should serve to enhance rather than retard career prospects within the seconding authorities. It would help to develop better team working and more sophistication in evaluation although a balance would have to be struck between core members of the team on secondment and those appointed ad hoc in order to match membership with the focus of the visit.

Programme of visits

12. Whilst many visits are thought to be helpful and successful the system of visits in general requires attention. The programme has become somewhat rigid in concept and administration as follows:

(a) programmes are thought to be 'building-oriented' whereas the emphasis in the two main HAS specialties ought to be that of community care;
(b) the visits are concentrated on health authorities with the result that insufficient attention is paid to the social service authorities and to the key area of joint action between health and social services;
(c) the visitors have insufficient time to penetrate issues of general management and strategic and planning issues;
(d) the HAS programme is not necessarily well adapted to evaluating how changing needs are met. For example, the elderly mentally infirm have emerged as a key group, but they can be left on the margin of visits to services for elderly people and mental health services.

The final feedback meeting

13. The form of the final feedback meeting is necessarily summative but it need not be prescriptive in style. As it stands, it allows no opportunity for challenges to the findings and undermines the notion that the visit has been a developmental rather than an inspectorial

event. This perception is compounded by the lack of time for informal feedback and testing before the final session.

Reports

14. At the time of our study, the writing of reports was framed by the HAS standard format for presentation. This was thought by members of teams to be somewhat institutional in bias, and to canalise thinking in disciplinary and service areas rather than towards multi-disciplinary, joint or integrated work and service development.
15. The uncertainty of objectives is one reason why it is difficult for teams to decide how to present their recommendations. If too critical, their report might not be the starting point for a benign change process. If, however, HAS is expected to attest to standards, criticism cannot be avoided.
16. The impact of the visit is experienced from the time preparation begins. But given the delay between the visit and the publication of the report (five months at the time of our study, now to be reduced to four months) the final plenary meeting is crucial in presenting a comprehensive account of the team's judgements.
17. Authorities may correct only matters of fact and not challenge findings. It could be argued that the authorities' commentary on the Report should be published with it.

Follow up arrangements

18. The HAS has limited resources. We consider later whether there are other ways in which these might be used. At present, however, it is difficult for the HAS to act as a developmental resource in visits which cannot easily include both summative evaluation and interactive follow up with those whom the visitors meet. The follow ups are brief and at a distance of time from the original visit. In these circumstances the authorities visited carry the main onus to determine the focus of change. But we have noted that receiving authorities are usually reactive rather than interactive. The DHA and the SSD emerge as the passive recipients of the evaluation, rather than active participants in a developmental process.

Substantive focus

19. HAS at present is primarily concerned with assessing the quality of professional services given to patients and clients and of their

environment. In our view, it is necessary, not least to help improve the quality of service, for the management and planning of the services to be more prominent in the evaluative concern. Nor can any public service exclude consumer experience from its frame of reference; this issue, so important for the most vulnerable group covered by HAS, is raised by the proposals contained in the 1989 NHS review (see paragraphs 29 to 32 below).

20. A second issue of focus is whether the HAS should follow the line of analysis created by its access through health authorities and, to a lesser extent, social services authorities or whether it should start with a more central concern with the client groups with whom both kinds of authorities work. At present the emphasis is undoubtedly that of the health authority. If so, it would follow that the Health Advisory Service might be explicitly reorganised so that the social services components do not derive from the Social Services Inspectorate, but that an advisory service independent of existing mainline governmental bodies such as SSI should be created which can combine field as well as managerial expertise on both health and social service authorities.

Authority and evaluative modes

21. In our view, HAS works primarily in the mode of liberal summative evaluation. That is to say, it reaches judgements which it then leaves with the authorities visited to pursue. For it to work in a formative mode, that is to say, one in which it feeds back findings for reiterative shared development with the authorities concerned, a wholly different pattern of resource would be necessary. This is unlikely to be endorsed. Therefore the summative mode of HAS may need to be strengthened. It can focus the agendas for visits on the basis of a prior analysis of the problems being faced by the authorities being visited. It can then select the membership of teams so that their expertise, together with that of a seconded core of HAS staff, fit better the tasks to be performed. It can remove some of the more ritualistic aspects of the visit, and particularly the present art form of the final meeting, a matter already being attended to by the present Director. It can open itself to a larger degree of interaction with the visitors both in the course of the visit and before the report is made final. None of these would cause substantial increases in expenditure; resources for them might be found by readjustments of the workloads in other ways.

22. But issues of authority need to be more directly addressed. External evaluation was undoubtedly seen by participants in our

study as an important source of authority. However, the authority of the HAS was widely thought to rest heavily on the professional status of team members. HAS's mandate to report directly to the Secretary of State did not have noticeable impact on those visited.

23. The judgements made by teams were thought to be made on implicit evaluative criteria and models of service rather than to derive from explicit standards, research based knowledge or planning technologies.

24. Impacts therefore depended strongly on acknowledgement in the authorities of the status of the visitors, on a perception of shared values and objectives and on the establishment of a working relationship between the visitors and the visited. They did not derive from the authority of objective knowledge or from structural power.

25. Many people felt that, in consequence, HAS had less impact than it should. Even if the status of teams was secure in the perception of the peer groups visited, and this was not always the case, it might cut less ice in the parts of the authorities with power over allocation of resources and strategic priorities.

26. Could the HAS be given more authority? The combination of a stronger analytic resource in HAS with more careful and collaborative preparation could enable visits to begin from a more explicit set of standards and criteria. The authorities' objectives, priorities and models of service could be more fully articulated; HAS could make clear the basis of its analysis and teams identify their knowledge base and values. This might mean that the knowledge base of the process was seen as more authoritative.

27. But HAS might also be given more structural power. For example, authorities might be required to incorporate their responses to HAS advice into updated planning and review statements. Action on advice that was accepted might then be an element in the performance targets set for managers and authorities. This would strengthen the inspectorial dimension of HAS. It could be seen as potentially punitive to those struggling to maintain and develop under-regarded services, but that need not be the case. Such an approach could clarify where improvements in the quality of service depend on more effective planning, management and reallocation of resources across the authorities.

Different forms of visits

28. Our earlier proposals for enlarging the range of concerns of the HAS may seem to conflict with our suggestion that visits should be more rigorously focused. It is not, however, necessary to assume that

all visits should cover the full range of HAS concerns. Some modifications to the established practice might yield a better return for the expenditure of resources and commitment and sharpen the focus of visits. Certain kinds of specialist evaluation might be possible within a far shorter period of time. In particular, critique of management and planning systems may not require as much field work and interaction as do issues of services to patients and clients. The offer of a consultancy service of this kind could go alongside, but be distinct from, the maintenance of a service which attests to the quality of service to clients. An associated issue would then be whether the consultancy element of HAS at least might be financed by the authorities which receive the service.

HAS and the 1989 White Paper

29. The proposals contained in the 1989 White Paper, *Working for Patients* (DHSS, 1989) which was published soon after we had completed the analysis of our material and the writing of this report, might affect the future working of HAS in several ways. It is not proposed to recast HAS; instead, many of the qualities which could be enhanced by altering its focus and process are to be encouraged by other means.

30. The Audit Commission is to extend its remit to the NHS in England Wales. The Commission concentrates on efficiency and on helping to establish a more business like approach. Unlike the HAS, its evaluations are expected to be and are summative and it is now intended that it will cover the full range of NHS organisation and activities. As with HAS, considerable weight is given to the involvement of independent professionals, including medical and nursing staff, working in multi-disciplinary teams but working alongside a core of the Commission's own staff. Like HAS, the Audit Commission is seen as providing an independent source of advice to Ministers and its advice will, similarly, be published although, unlike HAS, it will be made available to Parliament.

31. Medical audit is also to be established nationally within hospitals and general practice. This, as its title suggests, is to be medically led and concerned with the quality of medical services. However, it is proposed that the general results of medical audit should be made available to local management. If they are concerned about the quality or cost effectiveness of a service, they can initiate an independent clinical audit carried out by external professionals or by a multi-disciplinary appraisal of a particular service.

32. Neither the Audit Commission in its quest for efficiency, nor

medical audit in evaluating clinical judgements, will, however, supplant the main functions of the HAS. Instead, the HAS may gain a new function. It is intended that the arrangements proposed in the White Paper will strengthen the choices of NHS clients in the use of services on offer. A future task for HAS might therefore be to establish how far the professionals handling patients' choices succeed in meeting their needs.

Conclusion

33. Our evaluation enables us to reaffirm the perceived need for HAS and points to ways of connecting a new analysis of its objectives to a reordering of its ways of working. Given the ability and commitment upon which it has been able to draw both among its own staff and those it recruits in the field, we do not regard these as impossible tasks.

REFERENCES

Audit Commission, *Making a Reality of Community Care*, HMSO, 1986.

Barclay Report, *Social Workers: Their Role and Tasks*, Bedford Square Press, 1982.

Bennis, W., Benn, K., and Chinn, R., *The Planning of Change*, Holt Rinehart and Winston (2nd Edition), 1969.

Brunel University, *Evaluation of Management Advisory Service and Performance Review Trials in the NHS*, King Edward's Hospital Fund for London, 1984.

Bulletin of the Royal College of Psychiatrists, 1986.

Bulmer, M., *The Social Basis of Community Care*, Allen & Unwin, 1987.

Cope, D., *Organisation Development and Action Research in Hospitals*, Gower, 1981.

Cooper, J., *The Creation of the British PSS 1962–74*, 1983.

Crossman, R., *The Diaries of a Cabinet Minister, Vol. III*, Rinehart Winston, 1977.

Day, P., Klein, R., and Tipping, G., *Inspecting for Quality*, Bath Social Policy Papers No. 12, University of Bath, 1988.

DHSS, *Grey Book, Management Arrangements for the Reorganised Health Service*, 1972.

DHSS, *Davies Committee Report, Report of the Committee on Hospital Complaints Procedure*, 1975.

DHSS, *Health Services Development: The Health Advisory Service*, HC(76)21, 1976.

DHSS, *Health Service Development: The Health Advisory Service: Publication of Health Advisory Service/Social Work Service Reports*, HC(84)16; LA.(84)13, 1984.

DHSS/SSI, *Review of SSI Role in Relation to Health Advisory Arrangements*, May 1987, (Mimeo).

DHSS/Welsh Office, *Annual Report of the Hospital Advisory Service for 1976*, HMSO, 1977.

DHSS/Welsh Office, *Patients First*, HMSO, 1979.

Eyles, J., *The Geography of the National Health*, Croom Helm, 1987.

Goldberg, E. M., and Connelly, N. (ed)s, *Evaluative Research in Social Care*, Heinemann, 1981.

Griffiths Report, *NHS Management Inquiry*, DHSS, 1983.

Griffiths Report, *Community Care: An Agenda for Action*, HMSO, 1988.

Howe, G., *Report of the Committee of Inquiry into Allegations of Ill-Treatment of Patients and Other Irregularities at the Ely Hospital, Cardiff*, Cmnd 2975, HMSO, 1969.

Klein, R., *The Politics of the National Health Service*, Longman, 1983.

Kogan, M., and Henkel, M., *Government and Research*, Heinemann, 1983.

K. Lee and A. Mills, *Policy Making and Planning in the Health Sector*, Croom Helm, 1982.

Malin, N. (ed), *Reassessing Community Care*, Croom Helm, 1987.
Martin, J., and Evans, D., *Hospitals in Trouble*, Blackwell, 1984.
NHS HAS, *The Rising Tide*, NHS HAS, 1983.
NHS HAS, *Bridges Over Troubled Waters*, NHS HAS, 1985.
NHS HAS, *Memorandum for Team Members*, 1987.
NHS HAS, *Annual Report: June 1987*, NHS, HAS, 1987.
Nitsun, M., 'The Effects on the Organisation of Hospital Visiting Teams', *Bulletin of the Royal College of Psychiatrists*, March 1988.
Perrin, J., *Resource Management in the NHS*, Van Nostrand Reinhold, 1988.
Rossi, P., in E. R. House, *Evaluation Studies Review Annual*, Vol. 7 Sage Publications, 1982.
Royal Commission on the National Health Service (Merrison Report), Cmnd 7615, HMSO, 1979.
Scottish Home and Health Department, NHS Circular No 19/81(GEN)40: *Scottish Hospital Advisory Service*, 13.11.81.
Sinclair, I., and Clarke., 1983, 'Cross-Institutional Design', in E. M. Goldberg and N. Connelly, *Evaluative Research and Social Care*, Heinemann, 1981.
Utting, W., *Social Work Service*, No. 16, July 1978.
Watkin, B., *The National Health Service: The First Phase*, Allen & Unwin, 1978.
White Paper, *Working for Patients*, Cmnd 555, HMSO, 1989.
Yin, R. K., *Case Study Research: Design and Methods*, Sage, Applied Social Research Methods Series, Vol. 5, 1984.

INDEX

JRP

From the introduction by Robert J Maxwell

'The Health Advisory Service (HAS) has now been operating for almost exactly 20 years. This is the first detailed study of its effectiveness, and it is high time that such an analysis be published, for at least three reasons. First, the HAS aspires to be a major force in safeguarding standards of care for vulnerable groups of people, who suffer from long term illness and handicap: how well does it fulfil its role in this field? Second, its costs (£1 million per annum direct costs, plus some indirect costs incurred by health authorities and the Department of Health) are not wholly trivial: does it represent good value? Third, with moves being made towards more decentralised management — and (one hopes) towards closer coordination of a range of community-based services — there is a strong case for greater attention to standards: does the HAS offer a good model for agencies concerned with other aspects of health care?

'Not surprisingly, the Brunel research team found these questions hard to answer. What they have done, with great care and competence, is to describe how the HAS works, and reflect upon what they saw and heard in their investigation, against the background of their own longstanding interest in this field. The result is valuable, both as a detailed record of the workings of an important public institution and as a stimulus to further thought about this and other similar agencies.'

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