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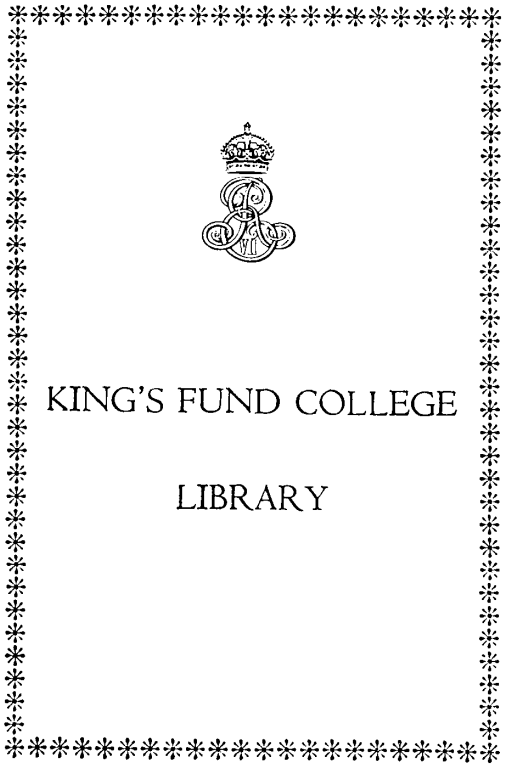
Caring For People: Local Strategies For Achieving Change In Community Care

Edited by CHRIS HEGINBOTHAM



Caring For People:
Local Strategies For Achieving Change in
Community Services

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CARING FOR THE PEOPLE

Local Strategies for Achieving Change In Community Services

Based on the proceedings of two seminars at the King's Fund in early 1990

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CONTENTS

PREFACE

Since the publication of the community care White Paper "Caring for People", the King's Fund College has run a number of management development programmes and other seminars to explore the implications of the policy directives . In January and February two seminars were held at the King's Fund Centre; and the College ran a series of three day management development programmes entitled "Achieving Change in Community Services". Much of the discussion at those seminars and programmes is encapsulated in this paper.

Like those discussions themselves, this paper is not offered as a finished product defining a step - wise approach to change in community services. It is more a set of overlapping analyses which people at these events found helpful and which we think may therefore be of wider interest. It is perhaps a collection to be sampled rather than a text to be read.

"Local Strategies for Achieving Change in Community Services" is intended to do two things:

* to offer some thoughts on the implications of the White Paper "Caring for People" in the context of other government policy, notably that set out in the preceding two White Papers;

* to suggest some lines of management action if effective change is to be created.

The paper is not intended simply as a critique of government policy, but rather as an exploration of the opportunities and constraints inherent in that policy and some of the processes which may be required to put the policy into effect.

A fundamental tenet of this paper is that the needs of service users are paramount. Government policy explicitly states that community health and social care should (a) start from the needs of those it aims to serve through assessment and care management systems and (b) use the commissioner/supplier relationship to enable and develop a range of collaborative facilities to be developed to meet that need. To do so requires effective inter-agency collaboration between the health service, social services, housing agencies,and a range of voluntary and private organisations. Such inter-agency collaboration will not always be easy as the history of the last twenty years demonstrates. But there is now a 'perverse incentive' within Sir Roy Griffith's proposals as enshrined in the White Paper. To do nothing is now not an option. Not to collaborate will lead to such potential chaos that service users needs will be less well served in future than they are now.

Many health and local authorities recognise that the importance of effective collaboration is more essential now than at any other time in the last two decades; yet there are significant barriers to such collaboration. Differing planning cycles, differing philosophies, and differing professional approaches all challenge the development of good relationships. At the same time the extent and speed of change is such that many managers and staff feel overwhelmed by the sheer enormity of the agenda.

Here we would argue that the Government's decision to delay implementation of key aspects of Caring for People make it all the more essential, first that authorities work together to minimise turbulence over the next couple of years and second, use the time to ensure that people locally have worked out for themselves the most appropriate approaches to adapt as the placed changes are introduced.

This project paper offers some thoughts as to the processes required to develop those relationships and ideas on how such change can be lead.

Good leadership is essential at a time of rapid change; and this text links content and process in an attempt to offer helpful suggestions as to how policy can be put into practice.

This project paper is one of a number of King's Fund publications addressing issues of immediate concern in the development of community health and social care. A recent briefing paper from the King's Fund Institute by Virginia Beardshaw and David Towell on assessment and case management is an essential parallel paper; and another project paper by Chris Hawker and Peter Ritchie on the contracting process will also be of interest.

1 INTRODUCTION

The last two years have seen a sea change in national and local approaches to the development of community care. The roots of these changes can be traced back many years, but the recent history starts with the House of Commons Social Services Select Committee Report in 1985 followed by the Audit Commission's Report 'Making a Reality of Community Care' in 1986. That report was not treated with as much attention as it might have merited, because the then Minister of Health, Tony Newton immediately announced that Sir Roy Griffiths was to review the future of community care.

The Griffiths Report 'Agenda for Action' appeared in March 1988. It immediately caused considerable debate. Not only was Sir Roy promoting the idea of care management systems similar to those in place in North America, but he stated quite categorically that local authorities should be given clear responsibility for community care. Over the next few months, the Government's antagonism to giving further responsibility to local authorities became evident, but eventually Sir Roy Griffiths won. In the summer of 1989, the Government issued a response both on community care in general and on mental health care separately, accepting the bulk of Sir Roy Griffiths' proposal and proposing a further White Paper.

During 1988, the Government issued a White Paper "Promoting Better Health' on primary care, covering particularly the role of general practitioners. The NHS Review White Paper 'Working for Patients' appeared in early 1989 and the White Paper on community care 'Caring for People' was eventually issued in November of that year.

In most cases, social services departments will set up care management systems incorporating case management and care purchasing. In some places, independent care management systems might be established; and some local authorities might decide to develop and fund "third party" advocacy agencies speaking with and on behalf of the users of services, ensuring that the case managers act fully on behalf those users and are not too heavily constrained by financial limits or bureaucratic requirements.

By and large Government policy is to develop some form of care management as required by the theoretical approach outlined here. Both White Papers, 'Working for Patients', and 'Caring for People' need to be seen as part of a continuum of the same theoretical/ideological approach, whereby the contractual relationship between health authorities and its provider units is reflected in similar relationships between local authorities via their care managers and the range of private and voluntary agencies that will provide the bulk of care. However, it can also be seen (from Fig 5) that local authorities are establishing care management within their agencies but at a 'level' within the heirarchy equivalent to that of the provider unit within district health authorities.

Some have seen the 'Caring for People' White Paper as being predominantly of interest to local authorities, and the 'Working for Patients' paper as primarily of interest to the health service. This dichotomous approach is misleading and unhelpful. The general thrust of Government policy is to establish competition amongst the providers of health and social care, giving health authorities and local authorities an 'enabling' role as commissioners of health and social services. All three White Papers should thus be read together.

One additional problem unforeseen at the time of Sir Roy Griffiths' Report, was his suggestion to give local authorities responsibility for 'community care'. It became evident that by this he meant 'social care' though it would appear that Sir Roy was intent on ensuring that local authorities took full responsibility for all social care including the purchasing and provision of residential and nursing homes. Though the White Paper 'Caring for People' contains within its key objectives a desire to clarify the responsibilities of agencies, some confusion still exists.

The main thrust of "Caring for People" is a desire to promote new ways of providing community services, especially helping people to continue to live in their own homes for as long as possible. This has two effects: on the one hand, the White Paper emphasises the role of carers and the need to provide respite, day and domiciliary services; on the other hand, it underplays the need for appropriate residential and nursing home care for some people. The danger with this approach is insufficient money for those who need residential and nursing home care, thus taking away care from those with minor but essential needs.

The thrust of government policy - that of the enabling authority with competition amongst a

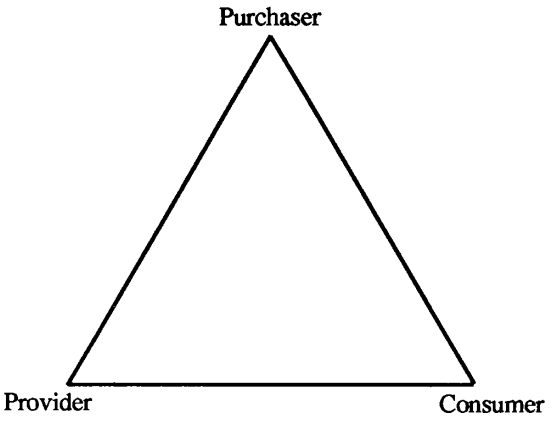


Figure 1

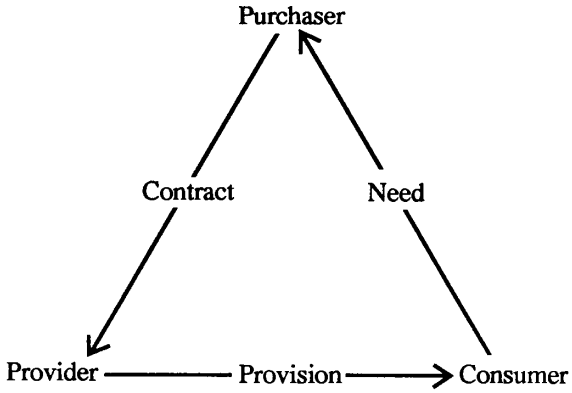


Figure 2

range of providers is part of the governments approach to encouraging a shift from the'bureaucratic encompassing state". In the past, local authorities and health authorities have been both purchasers and providers of care and at the same time have undertaken their own quality checks and made decisions about consumer need. This can be shown as a triangle as in Figure 1.

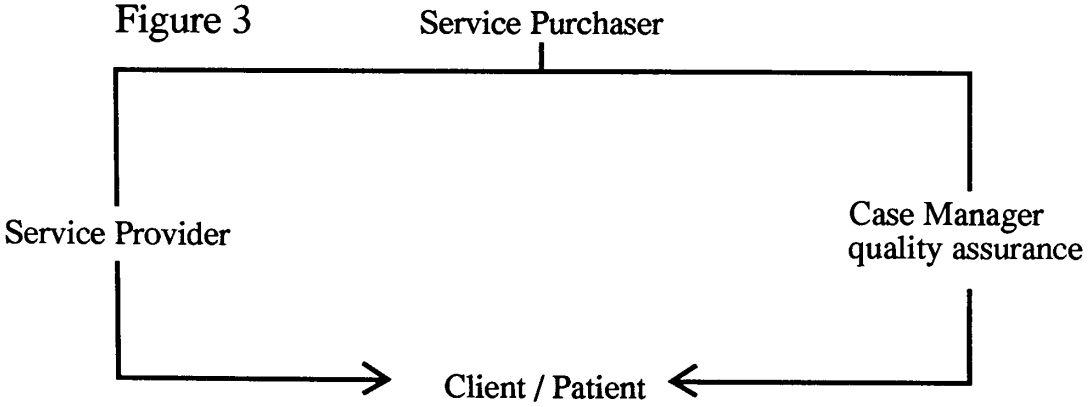
Behind Government policy is an attempt to split the three corners of the triangle from each other, creating greater accountability, delegation and consumer involvement. This is to be done by various financial levers, (eg the change to the welfare benefit system and the provision of some money to local authorities to purchase care) and by mechanisms such as a contract/service agreement. In other words, the triangle becomes that shown in Figure 2.

For community services, this approach helps in thinking of the role of care management systems, in particular the role of the case manager as responsible for finding ways of meeting an individual's need. The service triangle can be expanded in the following way to incorporate the concept of the case manager.

The case manager is responsible for assessing and agreeing the requirements of the person needing service and of negotiating with the service purchaser to make the necessary resources available. The service provider is usually given an actual or notional budget with which to meet the person's requirements. Within agreed or delegated limits the case manager need not seek the agreement of the service purchaser before contracting directly with the service provider.

Figure 3 is drawn with continuous lines which in organisational terms denote a direct accountability of one party or person to another. With the advent of contracts, a dotted line relationship (denoting no direct accountability) would be established as follows (Figure 4)

Figure 3



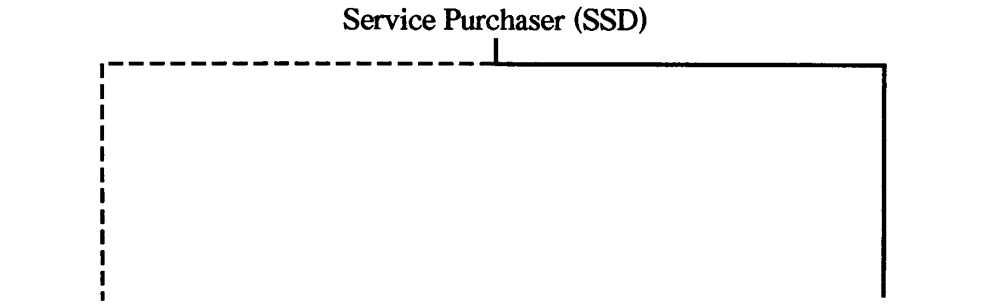


Figure 4

This leads to a requirement for agreements at different levels as indicated in Figure 5. The local authority is responsible for developing community care plans and agreeing these with the relevant health authorities; the health authority will be establishing forms of contract / service agreements with its provider units (and is responsible for care programmes for discharged mentally ill people) and they in turn will be establishing assessment and care management procedures with the care managers of the local authority. This creates a further triangular relationship in which three sets of agreements must dovetail to ensure that services can be delivered effectively (Figure 6)

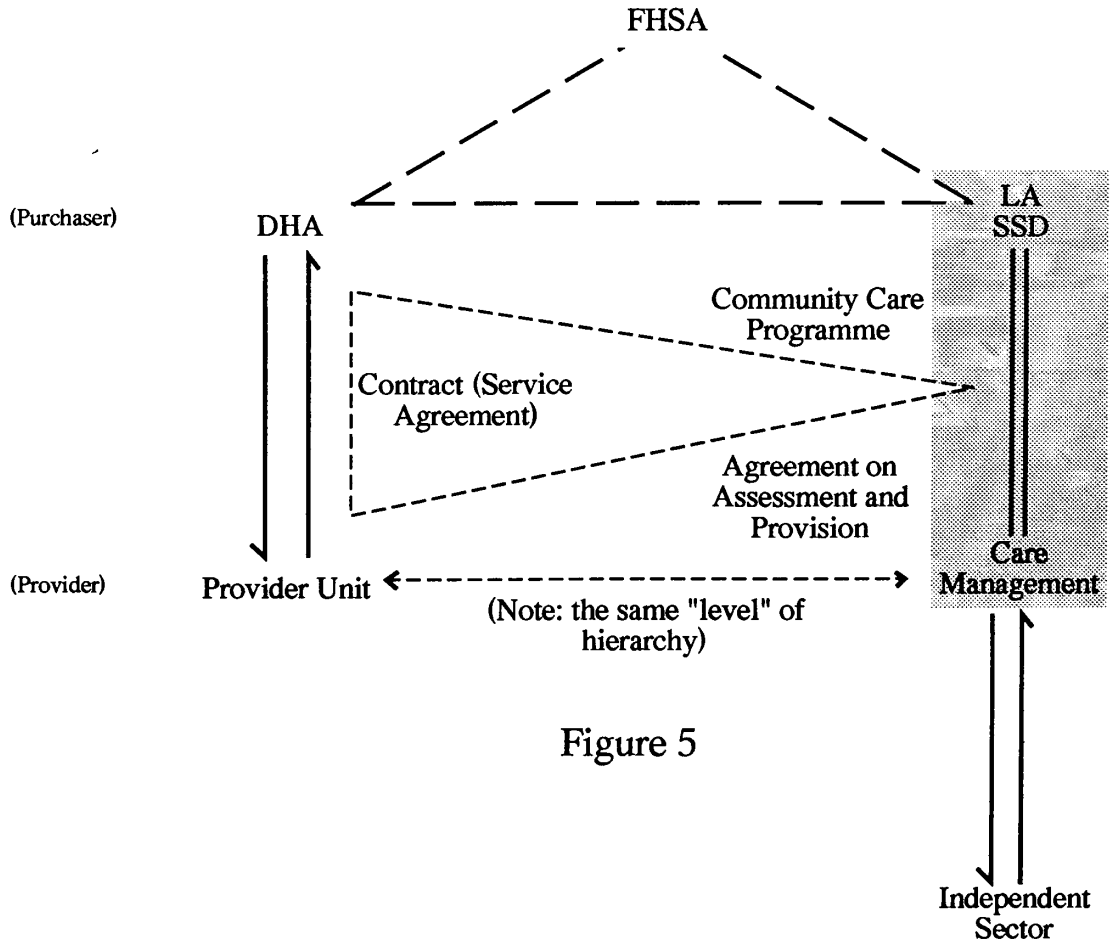
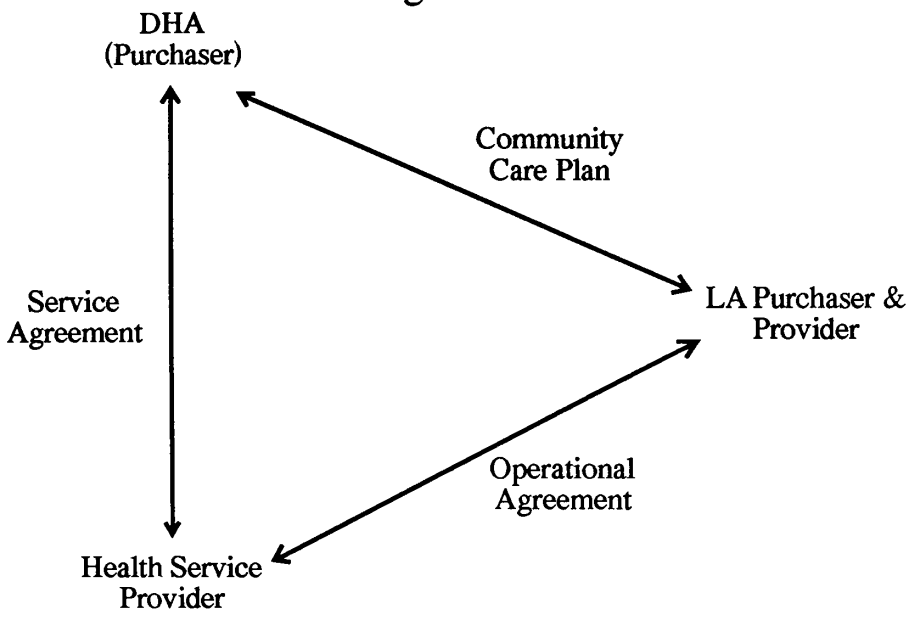


Figure 5

Figure 6



The next section explores these issues in greater detail. The discussion then considers the role of commissioning, the nature of contract, and the development of effective quality assurance. Inter-agency working is discussed in greater detail, followed by a consideration of leadership and change management required. Some of this would be relevant in any situation, but it is particularly important with the large agenda of community service development that any consideration of the changes needed must also take into account the way in which that change is brought about. Inter-agency relationships are then discussed, followed finally by a brief resume of local strategies for change.

2 ACHIEVING CHANGE

The changes set out in the White Paper 'Caring for People' are designed to have a fundamental impact on the relationships between providers and receivers of community care. The thrust of policy towards a 'pluralistic' and multi-provider future should not be viewed solely as the outcome of government direction. Rather, it presents a particular view of what the future pattern of community care should look like. In reality many more actors, going back through the Griffiths and Wagner reports to the House of Commons Select Committee on Social Services and Audit Commission interventions, have helped to shape the changes now occurring.

The nature of these new relationships in community care need further exploration, particularly as they suggest a more central place for 'consumerism' and greater levels of accountability for statutory and voluntary service providers.

The simple pattern shown in Fig 7 has dominated community care for many years, and has many defects:

* Consumers have to search out an appropriate referral point. Without adequate information this will not always be a statutory agency. For any particular client group statutory agencies will often have a community team (of one kind or another) whose resources are insufficient to enable it to deal comprehensively with all the referrals it receives. It immediately has to decide priorities,even to the point of whether to provide an assessment or not;

* Some assessments carried out by professional staff or community teams are, by their nature, incomplete. They seek to deal with problems at hand, usually under pressure from lack of time or resources;

* Statutory and voluntary agencies operate under a basic conflict of interest. When assessing people for service provision it is very difficult not to have in mind the existing pattern of services available. Statutory social workers who assess consumers, are constrained by the choices available. Places are "meant" to be filled up whether or not they are appropriate;

* Imperfect communication, organisation, liaison, joint planning, collaboration and information all conspire to further limit the range of choices or opportunities available to the consumer;

* Services provided in this conventional way are difficult to change or adapt. A constant pressure exists to re-affirm existing models of care;

* Consumers have very little real choice.

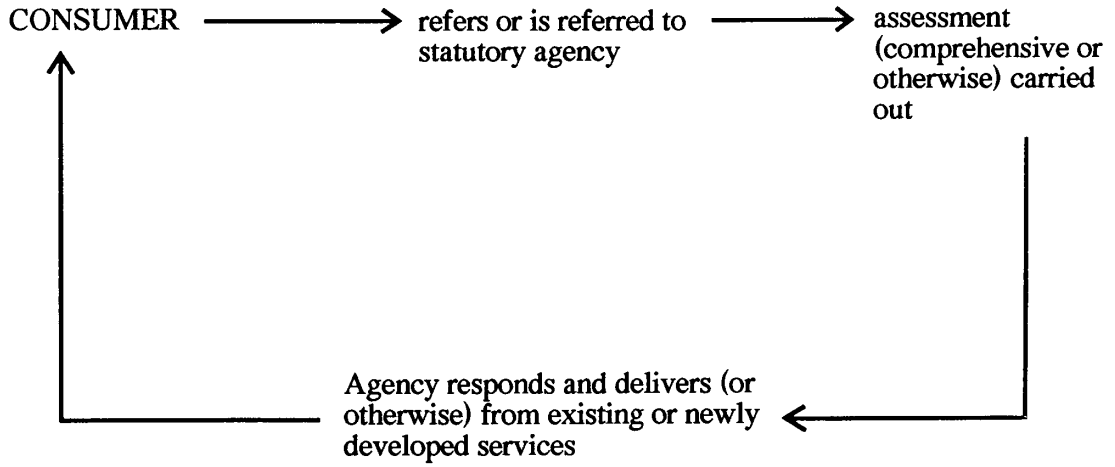


Figure 7

This is by no means a comprehensive or original list of grievances. Nor does it fairly represent the actual nature of service delivery that exists in many areas. But the points made here seek to demonstrate the overpowering need to change the framework of community care without even thinking of the problems of conflicting priorities, too much demand and too few resources.

The Need For Change

For many years service planners and managers have sought a rationale for radical change. Until now this has come from a perceived wish to make existing and new services more responsive to community needs. Such an aspiration is easy to state, but difficult to achieve. The challenge can be presented diagrammatically:

Box (A) represents the pattern of services which exists, appropriate or otherwise.

Box (B) represents the new pattern of services required within the same existing envelope of finance available - and could be taken to reflect Sir Roy Griffith's aspiration to make better use of the resources already available before argueing cogently for more.

Box (C) represents the broader pattern of services required in relation to the collective aspirations of the community.

Some further points can be made:

* existing services which fall outside boxes (B) and (C) are inappropriate and need to change dramatically;

* it is reasonable to expect that in high quality community care the resources deployed in Box (A) which do not overlap with Box (B) should be redirected to Box (B). Many day centres for example represent large 'locked up' resources of staff, buildings and money;

* Box (C) becomes the legitimate aspiration for growth in services once the transition from Box (A) to Box (B) is made.

The perceived direction of community care policy should be to achieve services based on the needs and aspirations of consumers as quickly and effectively as possible. Conventional patterns of services are geared more to the producer than the user of services thus the debate about the White Papers (and their implementation) should focus on the means offered for acheiving a new set of ends

New Relationships

The White Paper confirms the drive towards pluralistic service provision with local authorities largely in the lead role. This re-alignment of responsibility brings with it greater levels of accountability. As local government social services departments are charged with enabling roles there will be a need to separate out their functions as providers of service from purchasers of service as shown here. The White Paper encourages local government to give up large chunks of its traditional provider base while being unclear about how the purchasing/enabling function can be developed.

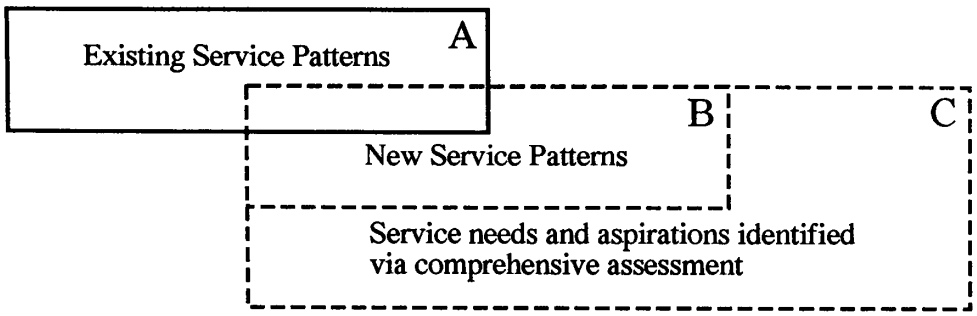


Figure 8

3 THE ROLE OF THE COMMISSIONER

The two White Papers - 'Working for Patients' and 'Caring for People' must be read together if the full implications for community services are to be understood. Both White Papers have a number of key features in common. These are:

* the split of commissioners from suppliers of services;

* the development of forms of contract (planning/service agreements) between commissioners and suppliers;

* a concern for services to be based on perceived needs rather than historic demand or service level;

* delegation of authority for budgetary control, quality assurance and clinical audit;

* achievement of the greatest possible choice in health and social care.

In the health service the commissioner/supplier relationship is seen predominantly in the planning agreements to be established between district health authorities and their provider units. Those units will, in the most part, for the time being remain directly managed; the development of agreements is not dependent upon the establishment of self-governing hospitals or services. Basing services on a range of contracts has both advantages and disadvantages. In principle, the nature of the contract (the service definition, the volume, quality and the price) is dependent on what the authorities (district health authorities, family health service authorities or local authorities) believe are the needs which must be served. But those needs are seen in different ways by different organisations.

From 1st April, district health authorities will be required to ascertain the health needs of their local population and to 'insure' their health care from a range of provider units appropriate to the needs which they believe must be met. In ascertaining need they will have regard to general epidemiological information, historic data of admission and discharge rates to existing services, some broad area data, and pressure group information from those organisations concerned with specific client groups. Social service authorities on the other hand tend to base their data on case information. Their approach is more localised, concerned more with social case work than with broad area information - though this is not intended to imply that local authorities do not have regard for the general social needs in their authority's area nor that health authorities have no concern for the individual. These divergent approaches create a potential tension in the development of service (See Figure 9). If provider units in the health service are working to contracts established on the basis of broad area information, and care management systems in the local authorities are working to case register type information, the potential exists for problems to arise in establishing "who provides what to whom".

At the same time opportunities are generated by this difference. Health authorities can require provider units to make available a general health service to those who are the specific responsibility of social services care managers. This will need negotiation between health authorities and local authorities, between provider units in the health service and managers of the care management systems in local authorities.

The health service provider units must make available staff for assessment, but it is the responsibility of the local authority to ensure that care management is established and that appropriate systems are developed to obtain an assessment for an individual. They should then use that assessment to devise a package of care appropriate to the needs of that individual, and ensure that package is provided, by purchasing care from a range of private and voluntary organisations, or from services directly managed by the local authority and offered on an "internal" market" basis.

The assessment is done within the context of community care plans drawn up within the health authority and local authorities concerned. It is thus

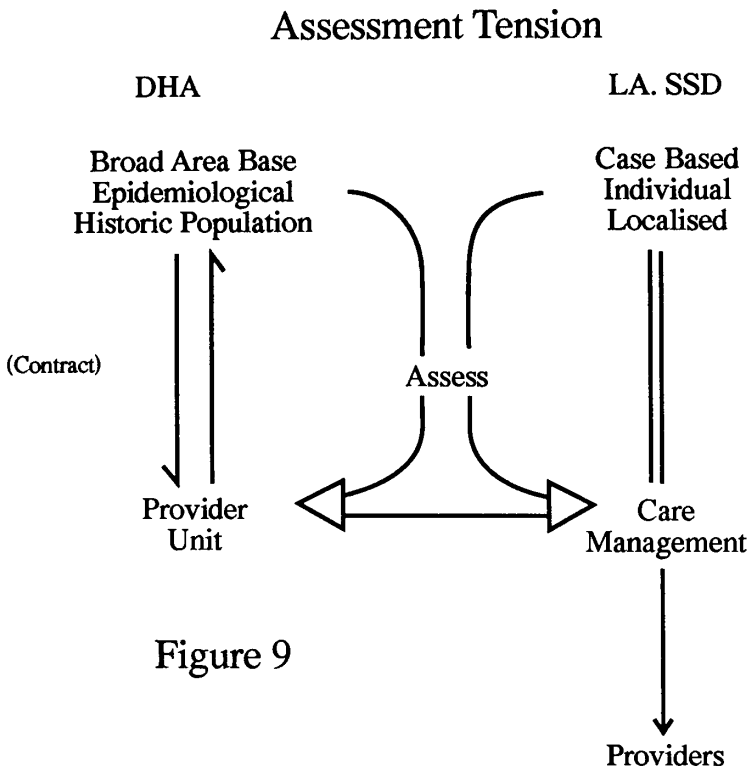


Figure 9

essential that before any system can become fully operational, the following will have been negotiated and agreed between the health service and social services departments:

* criteria for assessment;

* responsibility for assessment;

* arbitration in the event that assessments are not agreed between agencies;

* arbitration when a package of care is devised which does not meet the agreed assessment;

* agreement as to who provides in relation to the assessment and who pays;

* agreement to the provision of components of the package where these are to be provided by the health service rather than purchased by social services from the independent sector;

* the range of clients to be assessed;

* whether care management (or business management) is to be dovetailed into the assessment procedures of the health authority or will be entirely separate;

* the value base on which such assessments are to be undertaken;

* any other reasonable criteria associated with ensuring the quality of the service provided following the assessment;

* the role of the client's friend or advocate during and after any assessment.

It is likely that disputes will arise over assessments and particularly the care which is provided following an assessment. Some appropriate arbitration system is required between authorities and ought to be established at the outset. If clear criteria are set it is unlikely that such an arbitration mechanism will be required often; but if any disputes are likely to arise then pre-empting them with an appropriate system is likely to be beneficial.

It is essential that clients have the right to advocacy and that advocacy is fully funded and independent. Such advocacy could also be helpful in relation to quality assurance (see below). A decision on collaboration over care management is essential. For services to people with learning disabilities, and (probably) elderly people it is likely that the social services department will undertake the care management seeking assessments from the health service where necessary. For people with mental illness however, the establishment of mental health trusts or self governing mental health units may offer the opportunity for social services and the health service to collaborate in establishing community mental health teams which incorporate the care management function.

Such collaborative development could have the advantage of developing joint resource management information on the basis of a case-mix and services-available database.

Joint commissioning of services is another route. Joint commissioning envisages the health authority and local authority establishing a joint team or agency concerned with service purchasing and individual case management functions, buying in care appropriately from the health service, social services and from the independent sector.

4 THE NATURE OF CONTRACT

The commissioner-supplier relationship is central to the changes discussed in the two previous sections. For the health service this is manifest in splitting purchasers (DHAs) from providers (mainly existing health service "units"), for local health authorities it has taken on the guise of 'enabling' authority - especially for social service departments. In many ways this is a corruption of the original 'enabling' notion put forward by Seebohm and recently restated by one of the authors. In this the local authorities would develop a true partnership with the local community enabling and supporting community directed services. This contracting or enabling function will take place at a number of points in the system. Figure 10 shows an outline of the key 'relationships' in the new system.A 'purchaser-provider' relationship exists between the DHA and a provider unit, with the care management system of the local authority and those services 'bought-in' from a range of private and voluntary providers (the independent sector). An assessment relationship exists between the provider unit of the health service and the care management system of social service departments; and the health service provider unit may offer services directly to clients or provide professional services into the independent sector complementary to the care 'bought' by the care managers.

We can see from this simple diagram that a number of contracts will have to be established. A form of quasi-contract or service agreement will have to exist by 1 April 1991 between the DHA and its provider units. Community care plans - although not required formally until 1992, but a key element in effective inter-agency collaboration - must be negotiated and written by the local authority and agreed with the health authority, establishing the type of service to be provided, and making some statements (albeit very broad statements) about who provides and who pays for care and an agreement will have to be reached between the

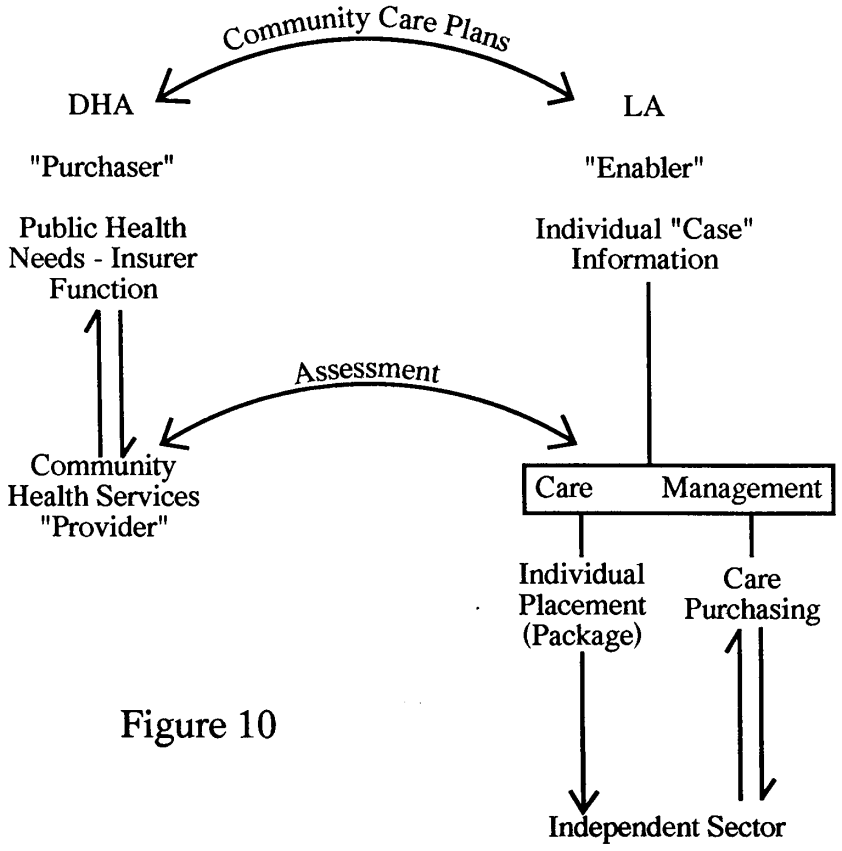


Figure 10

NHS provider unit and the social services department over the nature and process of assessment. This will have to fit in with the community care plans agreed between the DHA and the local authority. In the reverse direction the social services care managers will negotiate contracts with the NHS provider unit for certain types of provision, especially that which the NHS will provide to the independent sector or directly to the local authority. Agreement will then have to be established between the local authority and the provider agencies in the independent sector. Such agreements will probably be in two parts: a contract entered into by the care purchasers, essentially a retainer contract, which will ensure that the provider is available to provide care to individuals; and contracts for individuals setting out their personal requirements in the form of an individual programme plan.

In this system, all the contracts or agreements must be compatible. The individual programme plan contracts must allow a certain flexibility for the case managers to write in the needs of each client and to ensure that those needs are met within the context of the services available. That IPP contract must be compatible with the retainer contract and with any agreement entered into between the social services department and the NHS provider unit, if the NHS is to offer certain services free of charge (for example: community nursing services) to independent providers. In the social services department, provision will increasingly be made on an "internal market" mechanism. All these agreements must fit within the broad terms of the community care plan entered into between the health authority and the local authority (itself a form of contract), or at least ought to be treated as just as much a contract as the purchaser-provider agreements within the NHS. In many ways community care plans and agreements between the NHS-provider units and social service departments are planning agreements written in contract form. The contracts between the care managers/care purchasers and independent provider agencies are, however, much more clearly 'contracts' in the traditional sense.

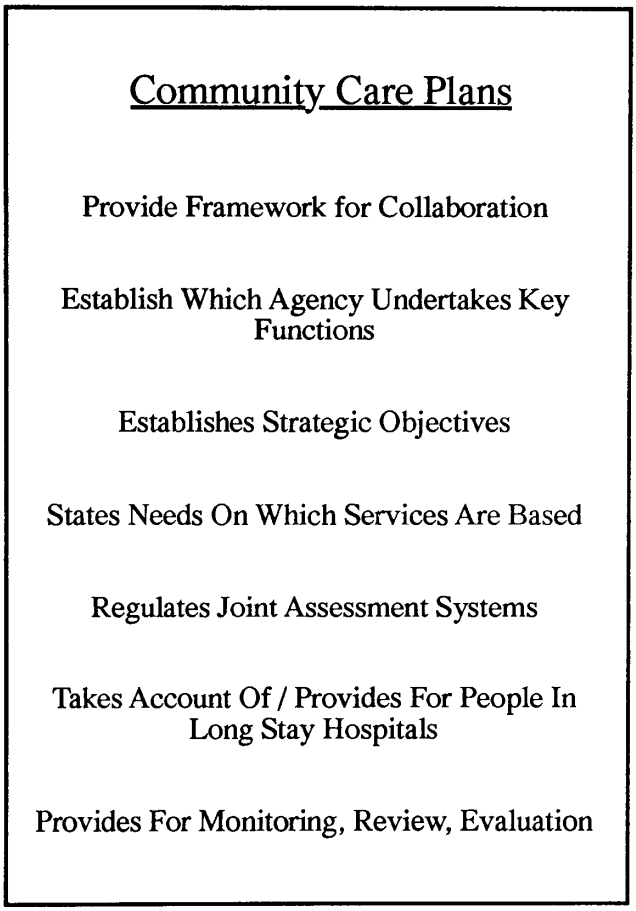


Figure 11

Agreements will thus have to be compatible but written in as robust a form as possible. Contracts between independent providers and the social service departments must be such that specific performance can be required. They will therefore have to be sufficiently detailed so that enough information exists on which a judgement can be made. Simply stating that a provider will have to have regard to the best possible care to the individual or to work within some very broad code of guidance will be insufficient. This will be true even if the code of guidance is part of the overall contract form.

5 ADVOCACY & QUALITY ASSURANCE

Quality assurance is concerned with the measurement of performance against established objectives with the intention of making appropriate changes to improve performance over time. Advocacy is essential in any human service delivery but especially where care management systems are established with fixed budgets. Advocacy is thus an important safeguard and check on the bureaucracy as well as in itself a form of quality assurance. Both topics are thus taken together.

Quality has been defined as 'excellence in the deployment of skills, abilities and capacities leading to the attainment of a service which is relevant, flexible and accessible and,meets the needs of clients and community alike' (MIND / Richmond Fellowship 1990) Robert Maxwell identified six 'dimensions' of quality: accessibility, relevance, effectiveness, equity (as fairness), social acceptability and efficiency/economy. These are not mutually exclusive concepts but demonstrate the importance of quality as a consumer related activity. Other definitions of quality include: 'continually satisfying customer requirements' and 'a commitment to excellence'.

In community and long term care, quality is essentially concerned with the life of the users of that service. Too often, however, the quality of life of service users is not seen as the paramount aim of quality assurance nor necessarily of the service itself. Donabedian suggested that any quality system could be broken down into the three components of : structure, process & outcomes.

It should be noted that the third of these is outcomes not outputs. There are both inputs and outputs to the structural aspects of any service, to the processes which go on in the service, and to the outcomes for users. Many quality assurance systems currently in operation focus on structural concerns. The inspection and registration functions of local authority staff within the remit of the Registered Homes Act 1984 is predominantly with structural matters - fire precautions, numbers of staff, qualifications and training of staff, and so forth.

Checking on and monitoring the quality of the processes of care and treatment which go on within an establishment, or the management processes and staff/manager interactions is much more difficult. More difficult still is to measure the quality of life of the users of a service or the quality of outcomes of care and treatment. Yet it is those which are vitally important in the development of care. Some progress is now being made as the Social Services Inspectorate publication "Homes are for living in" demonstrates quality assurance is not something which is done by just one agency or point within the system. Quality assurance is a function of third party advocacy; it is a function of the members of health authorities and local authorities in their visiting role; it is more obviously a function of the inspection and registration systems including the current local authority registering offices and the new arms length inspectorates; it is a function which must be undertaken within contract management under the care management systems; and it is a function which the providers themselves must undertake and could be required as an element of contract.

Quality assurance is concerned with the management of change. It is insufficient simply to measure quality if there is no follow up to that measurement. Nor is it simply acceptable to impose quality assurance from the outside. Imposed external audit is necessary, but good quality assurance demands the involvement of staff in developing systems and in the application of those systems. Quality assurance must be management led, but involves staff and the users of services to create 'ownership' of the system and any changes which it requires. A further publication on quality assurance - 'The Enquire system" has been produced recently by the King's Fund College (1990).

6 COLLABORATION BETWEEN AGENCIES

To achieve any change in community services requires inter-agency collaboration. This has always been true and there are many who dismay of health authorities, local authorities, housing agencies and voluntary agencies working effectively together. The two White Papers which are principally concerned with here - 'Working for Patients' and 'Caring for People' - require effective collaboration and indeed offer certain, sometimes perverse incentives for joint agency working. The first of these incentives is to a degree negative - that lack of effective collaboration will lead to such a dreadful mess, particularly as perceived by the clients of the service, that it is in no-one's interest not to collaborate to some extent.

On a more positive note, there is an incentive to 'trade' between health authorities and local authorities. Local authorities will in due course be given additional resources with which to provide social care; but health authorities will continue to provide fairly large elements of social care within existing hospital based services for people with mental illnesses, people with learning disabilities and elderly people. At the same time, some local authorities are already beginning to ask whether health authorities will pay for the nursing or paramedical component of nursing home care or other community services; and health authorities are beginning to question whether they should pay for services traditionally offered by the NHS but which have a large social care element. Into this latter category fall such care items as bathing of elderly people by district nurses. As we have seen local authorities will be responsible for writing community care plans and developing effective procedures through care management systems. Community or priority unit services within the NHS will be working on contract to the DHA as purchaser for the provision of community health services. Some agreement will have to be reached as to the methods of assessment of any client requiring long-term health or social care for which the local authority will be either wholly or partly responsible; and for deciding on who pays for what provision. The local authority is responsible for devising packages of care and ensuring that that package is met from a range of providers, and will also be responsible for contracting with those providers. In addition, the local authority has a role through its independent arms length inspectorate in regulating and monitoring statutory, voluntary and private providers. General practitioners, too, will have an increasingly important role as referral agents and as purchasers of care.

It is thus essential that, with the increased responsibility on local authorities and with some increased funding, local authorities agree with the health service on appropriate assessment criteria and procedures and on what is meant functionally by social care and health care. This does not mean authorities should spend a long time writing esoteric definitions of health or social care. Rather, it is important that health authorities and local authorities come as swiftly as possible to agreements on what it is sensible they should provide and thus on who will pay. One way of dealing with this is for health authorities and local authorities to agree that they will continue to fund existing services (health authorities to continue providing social care in hospital based services where this is sensible; local authorities to pay for the nursing element of nursing home care) **unless** an agreement to a different arrangement meets certain criteria. An example of the sort of criteria which might be set are as follows:

* both the health authority and the local authority are entirely in agreement with the proposed arrangements;

* the health authority has not undertaken to pay for any social care for which the local authority has the right to charge;

* the health authority's agreement does not contravene regional or departmental guidance or policy;

* the agreement is based on a set of clear values and objectives for the quality of life of service users;

* the agreement involves collaboration with all appropriate voluntary / statutory consumer groups;

* effective procedures have been established to ensure that the agreement will work in practice;

* adequate funding and financial structures are in place;

* agreements are geared towards developing the most effective local services, and the transfer of social care on a reasonable but not extended time scale to the local authority;

* the health authority is confident that both authorities have the capability to perform according to the agreement;

* the processes of care (including assessment and case management) are fully agreed and will not lead to sudden or unforseen increases in cost to the health authority;

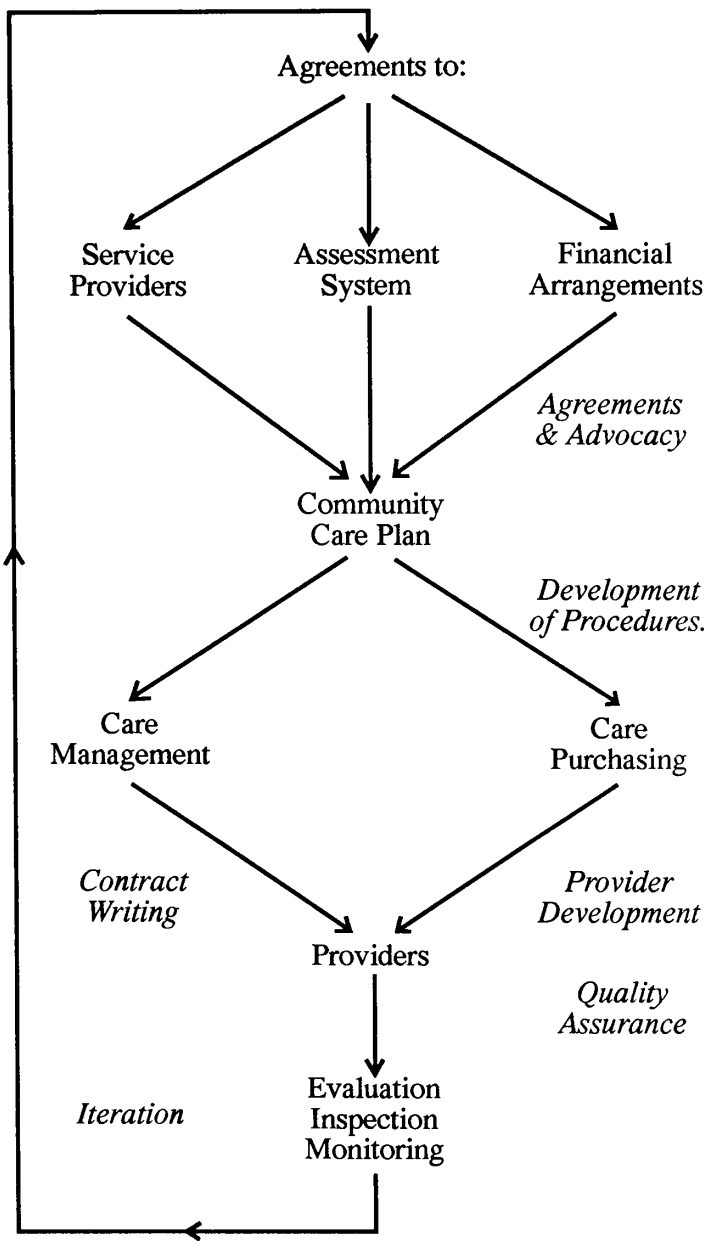


Figure 12

Evidently it is not only health authorities and local authorities that must come to some agreement. Local authorities will be responsible for buying in services from a range of private and voluntary providers. Will those providers wish to contract in this way? Will local authorities feel that these agencies are sufficiently robust, well managed and secure in their funding to entrust the care of very vulnerable people to them ? How will quality assurance schemes be devised ? And what will be the relationship between the arms length inspectorate in the local authority and the quality assurance requirements established by the contract between the care managers and the independent agencies ? Who will arbitrate in the event of disagreement or when contracts go wrong ? and what will be the relationship between those independent sector agencies under contract to the local authority, when there is a requirement to obtain community health services, either traditionally or currently provided by NHS provider units ?

This is a non-exhaustive list of questions, which will have to be met in devising appropriate agreements. As always, no absolute answers exist. It is also true that to set out the questions in this way creates what appears to be a very long agenda which in some ways it is. Nonetheless it can be broken down into 'bite sized chunks' and some systematic approach can be taken to considering each of the components. For example, it is unlikely to be helpful for a local authority simply to state its care management system and expect

health authorities to follow suit. One health authority may be working with a number of local authorities and find itself having to operate different but detailed procedures with each one. Nor would it be helpful, conversely, for health authorities to state the assessment criteria that they will use for assessing people for community care in the absence of a proper agreement with the local authority.

Consequently some form of process is needed, which enables all agencies to work through the main issues step by step. Figure 12 attempts to set this out on a very simple flow chart basis. It is essential that each agency has a view about who will provide what services, what assessment systems are needed and the financial arrangements required. These come together in some form of draft community care plan, which then enables the development of more detailed care management systems. That in turn requires a consideration of the providers of care, which then requires further thought about evaluation inspection monitoring. It will then be necessary to go around this loop two or three times, firming up different aspects at different stages.

There is no right way to proceed. Only by open minded negotiation will it be possible for health authorities and local authorities, and through them a range of other agencies to come to agreements on the key aspects of developing effective community services in the future. The next section looks at how such change can be developed in a principled way and how that change might be managed.

7 LEADING PRINCIPLED CHANGE

The greatest strength of any service is the people who work in it. Leadership demands skill and commitment to achieve change and provide the best possible care for service users. Threekey issues can be identified:

a. **The prime movers** of organisational change seem likely to be the over-committed members of the organisation. How, then can change be realistically tackled? Change is, at root, a people issue, for everyone not just a few keen managers

b. **Training needs** arise throughout the organisation as a result of White Paper agendae and other initiatives. Training must be addressed by organisations themselves and needs to be well integrated with parallel organisational and management development initiatives,

c **Recruitment** is likely to be a growing challenge, particularly with changes in demography in the coming decade. Recruitment into a visibly changing organisation creates new problems which will need tackling in new ways. The potential to respond well to training and development is likely to be critical in selection criterion; which in turn implies that training and development strategies and practices must be carefully designed and instituted.

Exploring these issues in more detail leads to a range of matters which need to be tackled if successful change is to be achieved:

(i) Patterns of employment and the nature of the potential workforce - the external environment

It seems likely, as Charles Handy and others have shown, that part-time work, and "portfolio" approaches and growth in home-based employment will be seen increasingly. Equally, new recruits to work in care and welfare services will come from the full age-range, and not be confined to school or college leavers. These changes can be used creatively and positively as a stimulus for helping to generate new organisational patterns and methods of service delivery. A particularly interesting idea is that of seeking explicitly to meet both service-user and service-giver needs simultaneously. For example, continuity of relationship between a staff member and client could be met by a few years' full-time work followed by a much longer period of part-time befriending.

Workforce variety and flexibility, driven by both cultural and demographic changes enhance existing organisations change processes as well as stimulate new ones.

Whilst time pressures are strong, it is important to manage transitions well, both within organisations and in the relationships between them. A crucial principle for successful transition management is to balance tasks and emotional work and to recognise genuine and reasonable emotional reactions. People are not always "rational" - quite understandably. When major change is afoot, a recognition of vulnerability and anxiety caused by uncertainty is important for keeping staff involved and motivated.

(ii) The essence of the changes in organisational culture and behaviour which need to take place

Health and social welfare organisations, like many others, need to move forward in a number of ways if effective change to provide services based on individual need to develop. Those changes will be from:

Present	to	Future
Centralist		Devolved
Controlled		Permissive
Bureaucratic		Empowered
Rigid		Flexible
Inhibited		Enabling
Maintaining		Developing/ Innovating
Corporate		Individualised

The purpose of these changes must be clear, ultimately to make maximum use of the potential energy, creativity and commitment of the people within the organisation in order to respond flexibly and effectively to the needs of the individuals who use its services. Some important centralist elements need to be valued. These include holding strategic responsibility and giving a degree of protection to organisational coherence in an uncertain environment.

It is essential to think about organisational design and culture for future, not present contexts. These will include the external world in general, workforce patterns and service types. Only then can the major immediate task of transition management be sensibly addressed. The way in which transitions are managed affects the change which results.

(iii) Specification and contracting

Although the prospect of specification and contracting for service delivery can be daunting and worrying, even to managers charged with that responsibility (let alone front-line staff and first-line managers), there are some positive incentives and rewards.

In order to achieve those rewards, however, the following issues need to be addressed:

* trust is essential, and may need building and reinforcing;

* contractual relationships need to be created which are explicitly good both for the people within delivery services and the people to whom the services are delivered;

* specification and contracting must seek to achieve a reconciliation between the apparent conflicts of, for example, relevance to local need and equity of access; both local and central assessment, strategies and specifications;

* workforce issues are not luxury extras; they must be identified, and included in both specifications and pricing arrangements.

Purchaser-provider separation, within health services/social services and the independent sector can more easily permit small-scale organisations to flourish. It is useful to think about where people would like to work (centrally? managing? delivering?). It may be helpful to re-think organisational design and purpose so that relative to the present, it is upside-down and inside-out with the service user as the focal point.

In summary:

* It is worth working with the people who do not appear to support change as well as with enthusiasts, and this may need to be at an emotional level. It is also important to create appropriate work opportunities in the new world which build positively on staff's existing strengths and aspirations;

* The White Papers must not only be seen in the context of wider changes, but also their implications broken down into coherent but manageable chunks;

* Small voluntary sector and large statutory sector organisations need to understand each other's cultures and perspectives better. This is worthwhile and need not take very long;

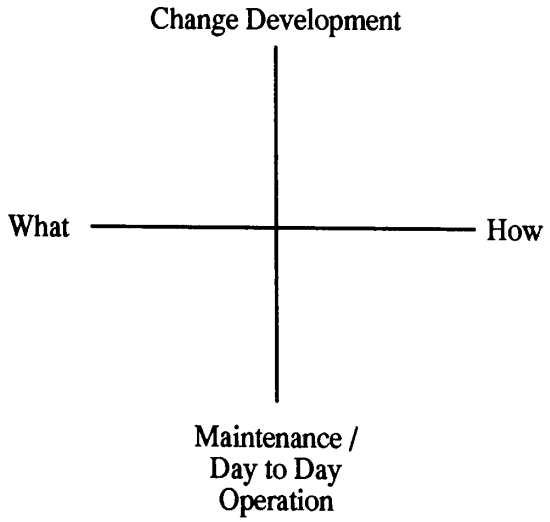
* Young organisations can learn from older ones that it is important to go for design not default. It is worth taking time regularly for re-appraisal of the medium-term and longer-term ripple effects of what is being done now.

* The external environment is changing, too.

8 OFFERING PERSONAL LEADERSHIP

As well as the continuing agendae for service development for community and priority groups' services are now confronted by complex organisational development demands, both strategic and operational. Despite the rhetoric of opportunity, there are risks of paralysis and a morass of short-term detail. The need for personal leadership is greater now than it has been at any time during the last fifteen years or so. This section highlights three key elements in exercising effective personal leadership for service development. That these elements are familiar makes them no less valuable to anyone seeking to address what at times seems uncomfortably like a world of adversity and chaos.

A very simple way of thinking about how our organisations need to function and the focus, which need to be integrated by effective leadership may be captured by this diagram, which draws on some classic work in this field including that of Richard Beckhard:



Both individuals and organisations will tend to have strengths in different quadrants, with corresponding weaknesses. Making these explicit can help sharpen both individual and collective efforts to address all four coherently.

"There is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success than to take the lead in the introduction of a new order of things"

-Machiavelli : The Prince

i) Vision

In recent years vision has become an over-used term. Creating vision can sometimes feel like a sterile exercise, akin to jumping through hoops. That is not the sort of vision fundamental to leadership.

Many community services begin their lives with energetic, committed and enthusiastic people. Without a shared vision which has real meaning, their energies may seem to be randomly directed and poorly co-ordinated. These energies either collide in destructive conflict or ultimately dissipate and collapse.

Terms like 'burnout' and 'organisational depression' are common currency and concern. Arguably one preventive strategy is actively to promote alignment of energy through clearly expressed vision which everyone can share. This sort of vision is genuinely principled, committed and enthusiastic and is constantly communicated. It is a vision founded on dreams and passions, which is intellectual, spiritual and emotional. Metaphorically, this kind of vision is the element of leadership which acts as a magnet to align and catalyse the energies of people in the organisation and thus makes reaching for the stars seem possible.

ii) Translation

Dreams and visions are not enough. Effective leaders work with others to translate visions through strategy into actions. Without this explicit translation, people may be left dreaming beautiful dreams, full of energy to achieve, but no clear idea of where to start or how to contribute.

The power of visioning then becomes an irrelevance to daily activity and the vision itself become simply an impossible, unattainable day-

dream. Alternatively, people may be very clear about which actions they are supposed to take, or which tasks to perform but, unless it is clear how actions and tasks will help to make the vision a reality, they soon feel like relatively empty drudgery or ends in themselves. Clarity on strategy and clarity on tasks which contribute to strategy, all linked to vision, help people both to know what to do and imparts meaning and purpose to their actions. The linkage with vision allows a clearer adaptation in times of external change and turbulence.

The idea of translation is a simple one. Perhaps it is so simple that it tends to get lost in everyday working life. The volume of tasks makes them ends in themselves, and visions, if we have them at all, get separated off into induction training, planning meetings, or even special conferences (like the one from which this booklet was derived)

iii)A Style of Action Which Express the Values in the Vision

Holding on to values and principles day to day is a difficult challenge. Expediency is an understandable response to pressures, but the long term consequences can be damaging. The stated principles of community services organisations tend to be about human dignity and worth, respect and the promotion of independence. If people within an organisation do not feel valued, it is very difficult for them to express the service principles in their own actions.

The principles of community services imply ambitious outcomes. It is as if organisations and the people in them are being asked to climb mountains. They may feel committed to reaching the summit (vision) and may have maps, plans and technical equipment and skills (translation into strategy and actions). The style of leadership will affect how they feel as they look at the mountain and begin to climb it. It will also effect how far they believe that others can climb mountains and that they can help them do it.

Seeking actively to live out the principles and values inherent in visions is a powerful way of creating an organisational culture which makes the achievement of visions a real possibility. It is important to think about the long-term consequences of the way in which leadership are enacted through the management of even mundane tasks.

In conclusion

The exercise of leadership is not restricted to people who are in charge of organisations. Sometimes, sadly, they fail to lead despite their position. Maintaining the status quo requires less leadership than bringing about change. Everyone has the potential and the opportunity to lead. Some may be gifted with intuitive qualities of leadership, but all can lead better by pausing to reflect and allowing personal development.

Given both the changes inherent in community services and the agenda of activity presented by White Papers, reflection and renewal using the dimensions highlighted here, will help in keeping faith, being steadfast, having courage and leading others towards achievement of visions in the real world.

There is a myth that leadership is a solitary role. Mutual support and mutual challenge founded on common principles not only help to prevent destructive conflict but also achieve more than anyone acting alone.

9 SYSTEMS CHANGE AND USER INVOLVEMENT

At the centre (Department of Health, Social Service Inspectorate, NHS Management Executive) work continues on the legislative agenda, on identifying resource requirements and in further defining policy albeit through the provision of fairly broad guidance. A range of development projects, involving the field, is also under way. Both health and local authorities are making progress with addressing substantial change agendae rightly without waiting for further specifications from government. However, this local activity varies in enthusiasm, clarity and the extent to which health and local authorities are working in partnership.

In relationship to the desirable intentions of the "Caring for People" White Paper (ie. in improving the support available to vulnerable individuals and their carers in leading more independent lives in the community) some positive attributes exists on which further progress can build. These include:

* wide acceptance of the criticisms of past performance and agreement on the need for change;

* initial guidance from the centre, setting out both a broad approach and concrete targets;

* availability of some significant external support for the management of change and some independent funding for research and development projects;

* some evidence that purchasers are developing quality specifications to shape service development in some places;

* some evidence that independent providers are strengthening their contracting capacity;

* emergence of some small scale independent providers committed to quality in non-residential services;

* recognition that the contracting process could be used to increase the sensitivity and appropriateness of services eg to ethnic minority users and carers;

* reinforcement of previously fragile efforts to introduce individual planning, case management and the costing of service requirements that start from individual need;

* in this and other areas, the growth of small scale projects on which wider change could build;

At the same time, a scan of current performance and trends raises several causes of concern, including:

* the danger that pressures arising from implementation of the community charge would seriously weaken the capacity of local authorities to invest in community care and siphon-off any extra revenue support grant into protecting existing commitments;

* continuing uncertainty about the resources that will be available and scepticism about the assumptions underpinning the transfer of resources from social security particularly now that the main transfer has been delayed until after the next general election;

* continued ambiguity about central expectation on what is to be implemented over the next year or so, and questions as to how radical are the intentions behind the White Paper;

* lack of clarity in many local authorities about the organisational and professional implications of the NHS and Community Care Act 1990 and the Children Act 1989 taken together;

* cynicism among users and carers about whether they will have any influence on these changes and whether they will be any better off as a result;

* preoccupation in some authorities with the wholesale transfer of traditional services into the independent sector and/or with rushing to 'privatise' residential services in order to maximise social security funding of services;

* local authority implementation strategies that

focused initially on major organisational restructuring;

* failure in some places to generate action across the NHS and local authorities (eg . to reach agreement on the way health and social care responsibilities will be defined and articulated);

* a common tendency for both middle-managers and field staff to be alienated from these changes;

Starting from the concerns of users and carers

services must become more responsive to the people who use them (either as direct recipients of services or there is a danger of all the changes being made at a systems level failing to impact positively on the lives of people who use services.

* User involvement covers a diversity of issues, ranging from asking people's views about plans to listening carefully to their views and experiences at all stages in the service planning and delivery process. It is important to include both people who use services directly (whether children or adults) and those who provide informal care (parents or others);

* There is merit in having a dialogue at the individual level (perhaps through the assessment and case management process) so that individual needs can be incorporated into the service planning and delivery process. It may also be important to listen to people in groups;

* Users should be involved in short-term decisions, affecting immediate issues of service delivery, but also in longer term planning, where their views will be vital in shaping the future pattern of services.

* It is particularly important to involve service users in the development of community based services for people with long-term disabilities. The population is a vulnerable one and there is a serious danger that policy changes and their financial and organisational implications could take place in such a way as to be irrelevant to the lives of service users or, worse, so as to cause additional problems. Furthermore, most community care is provided by informal networks of carers and others in the community, so it is vital that services support and encourage these networks;

A number of ways exist in which central government can give an impetus to the development of consumer involvement at a local level:

i) Sensitivity to consumer interests will be fostered when 'high level' planners and policy makers have personal contact with people who use community care services. In many cases, people have relatives or friends who use services, or else make a personal commitment to keep in touch with an individual or local service. It is clearly not possible to make such personal involvement a requirement of the work, but it may be possible to encourage people to develop personal links of this sort;

ii) In some services, much has been achieved already and it will be important to ensure that existing good practice is built on and recognised and that others have the opportunity to learn from the experiences gained;

iii) A clear focus on user outcomes should be given to any policy guidance or service development work. Managers and service providers should thus be encouraged to think about the implications for users of any changes in the service system. As part of good management practice, there should be a clear focus on the objectives of a service, in terms of its effect on the lives of people who use it;

iv) The government can ensure that consumer involvement is built into service specifications, and that this is included in any audit or review of plans. Central guidance could be given, together with illustrations of good practice;

v) Citizen advocacy is one important way in which the most severely disabled people can be given a voice. There are particular difficulties for citizen advocacy groups in obtaining funding which is independent of service providers. Whilst it may not be appropriate for central government to fund

individual schemes, the centre may be able to offer support to a national citizen advocacy office which would have the responsibility for developing and supporting local schemes;

vi) The centre may be able to fund demonstration projects and ensure that the lessons learned from these are widely disseminated;

vi) Central government agencies (such as the NDT and SSI) could model consumer involvement in their own work, thereby encouraging authorities to follow their example. Some progress has been made in involving parents in reviews of services, but more could be done to ensure that disabled people are involved also.

Locally, services which aspire to greater responsiveness will need to:

a) Set up situations where people can discuss freely their views on services;

b) Ensure that mechanisms exist to incorporate user views into quality control arrangements. For example, there should be an effective and well-publicised complaints procedure and, more positively, user feedback should be actively sought as an important way of monitoring quality;

c) Ensure that the service establishes a contract with the user, so that it is clear what the service sets out to achieve on their behalf and the ways in which users are to be involved are clearly specified.

10 LOCAL STRATEGIES FOR CHANGE

This short booklet has offered some ideas on how local strategies can be developed for achieving desired change in community health and social care. It is essential, not only to have a clear strategic purpose, but also to consider carefully how that purpose can be put into effect and how principled change can be lead and sustained. The first part of the booklet established the change agenda. The second part suggested ways in which appropriate leadership might be offered and some of the pitfalls of any change management process.

In summary, local strategies for achieving change will include:

* the importance of health and social services authorities starting from a clear sense of local purpose. Establishing objectives for a community service is essential but will have to be achieved through iterative negotiation in which all sides work towards trust and common goals;

* the establishment of inter-agency agreements both on purpose and on how common issues are to be addressed. These agreements will be reached after careful consideration by all agencies of their role in the development of care and on good natured discussion as to which agency will provide and which agency will pay for care;

* The production of community care plans which reflect joint agreements and which match contracts written between district health authorities as purchasers and their provider units, and any agreements reached between health authority provider units and the care management division of local authorities;

* the establishment of effective quality assurance procedures and cycles together with a system which encompasses the arms length inspectorate of the local authority, quality control through contract from the care managers, quality assurance within provider unitp (local authorities, health authorities or the independent sector) and quality assurance procedures required by health authorities. Within any quality assurance system, it is essential to move beyond structural considerations and to consider the inter-relationship of the processes of care with the outcomes as they effect the lives of service users,

* establishing processes that engage consumers and involve staff;

* the undertaking of a 'stock take' of good practice in current local performance (judged against desired outcomes), and related to information about local needs and the range of resources being deployed. The establishment of care management procedures by the local authority must follow discussion with health authorities and not be imposed. Similarly, health authorities must be sensitive to the local authorities' needs and not write service agreements for provider units, which are incompatible with local authorities' requirements. Other forms of inter-agency working must also be established, notably with housing agencies and the independent sector (voluntary and private agencies).

CONCLUSION

The agenda is large and complex. Only by developing a clear strategic framework will effective inter-agency collaboration be developed, which addresses quality of life outcomes for service users on the basis of change processes and care processes which are involving of staff and users. Over all these considerations hang the uncertainties of financial resources and grave concerns about potential disorganisation arising from the plethora of organisational and other changes expected over the next two years.

However. there is much that can be done in a phased way to prepare for these changes. This booklet hopefully has offered a few useful suggestions.

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Any one interested in publications or management and organisational development programmes is encouraged to contact the Programme Support Unit at the King's Fund College, 2 Palace Court, W2 4HS Tel: 071 727 0581 or discuss their requirements with the group coordinator, Dr David Towell.

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