BRIEFING PAPER

3

Promoting Innovation in Community Care

FROM SMALL-SCALE DEVELOPMENTS TO MAINSTREAM PROVISION

KING'S FUND INSTITUTE

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SUMMARY

The report is derived from a memorandum submitted to the Griffiths review of community care. The review was prompted by a critical report produced by the Audit Commission at the close of 1986. The Commission suggested solutions to the problems arising from community care and called for a high level review of these.

The report endorses the Audit Commission's diagnosis of the problems besetting community care while expressing reservations over its proposed solutions.

The report urges Sir Roy Griffiths to look critically at national policy as well as local policy on community care. Vigorous policy leadership from the centre is essential in order to provide a clear and coherent framework to facilitate the development of local services. Structural solutions are eschewed on the grounds that they are unlikely to address the real problem and will only act as a damaging diversion from what needs to be done. They should only be contemplated where other options have demonstrably failed.

The central challenge facing community care policy and practice is to make happen on a large scale what is already occuring on a small scale for a few people in some of the best services across the country. To this end, the report recommends the adoption of a set of measures designed to build upon what is already taking place in community care services in some local areas.

Other key points on the report's agenda for reform include the following:

- the need for clear principles governing service development
- responsiveness to consumer preferences
- decentralised service management
- continuation of multi-agency responsibilities
- improved joint planning and joint working between agencies, managers and providers
- the importance of attending to the *processes* of organisational and service development coupled with policy and financial incentives to promote change at local level where necessary.

In order to implement successfully the necessary changes, a policy and organisational learning approach is favoured. This has implications for the development activities of agencies such as the Health Advisory Service and the Social Services Inspectorate.

FOREWORD

The development and provision of community-based care has long been seen as a preferable alternative to long stay institutional care for the priority groups of elderly, mentally ill, mentally handicapped and physically handicapped people. For nearly a quarter of a century it has been an objective of successive governments.

The present government (DHSS, 1985, p1) has stated that

> *community care is a matter of marshalling resources, sharing responsibilities and combining skills to achieve good quality modern services to meet the actual needs of real people, in ways those people find acceptable and in places which encourage rather than prevent normal living.*

The challenge involved in realising these fine sentiments is a formidable one. Recent years have witnessed mounting concern that there is no clearly articulated national policy on community care. In its place there is much vague rhetoric, statements of intent and numerous *ad hoc* initiatives which only serve to draw attention to the absence of a coherent policy.

The report by the Audit Commission (1986) which triggered the review being undertaken by the government's adviser on the health service, Sir Roy Griffiths, was the latest and most comprehensive critique in a series of indictments of what often passes for community care. This is not the place to catalogue the various commentaries but it is worth mentioning that the Audit Commission's report was preceded by two influential reports: the Social Services Committee's (1985) report on community care with special reference to adult mentally ill and mentally handicapped people, which appeared in early 1985, and the report of the Working Group on Joint Planning (1985), representing the local authority associations, NAHA and the DHSS, which was published some months later.

Of the various critiques, it was the Audit Commission's which had the most dramatic and immediate impact. The report's strength lay chiefly in bringing together the various criticisms and concerns voiced over community care. The Commission concluded that regardless of the nature and terms of the policy, the reality as far as actual implementation was concerned was one of slow and uneven progress across England and Wales. The report identified five fundamental, and by now familiar, underlying problems to account for this state of affairs:

- distribution of funds does not match the requirements of community care policies
- bridging finance is needed to meet the transitional costs involved in shifting from institutional to community care
- social security benefit payments are distorting policy because they are more readily available for residential than for community care
- a fragmented organisational structure causes delays and difficulties
- staffing arrangements are inadequate so that staff are not being prepared for the move into the community or being recruited in sufficient numbers.

While the thrust of the Audit Commission's report is a firm condemnation of current policy and practice, it acknowledges that there has been progress in a number of local areas. Despite the important lessons to be learned from these local initiatives, the Commission concludes that there is a strong case for more far reaching structural changes to ensure that community care proceeds because of the system rather than, as at present, despite it. The strategic options for change identified for closer scrutiny all entail major shifts in responsibilities among local agencies and the redrawing of boundaries around them.

Whereas the Commission saw the failure of community care policy as an implementation problem, it could equally be argued that the problems to which the Commission and others have drawn attention are symptomatic of a failure to establish and operate a clear policy framework. Whichever way round it is, the government acted promptly in responding to the Commission's call for a high level review of the various solutions both it (and others) had canvassed. The former Secretary of State for Social Services, Norman Fowler,

invited Sir Roy Griffiths to advise Ministers within a year on options for action that would contribute to more effective community care.

Apart from Sir Roy's initiative, two other inquiries of related interest were already in hand at the start of his review. The Joint Working Party on supplementary benefit and residential care reported in July 1987 (Firth, 1987) and Sir Roy has been asked by Ministers for his views on its recommendations. The second inquiry is a review of residential care being carried out by a team chaired by Lady Wagner under the auspices of the National Institute of Social Work. This is due to report in early 1988 although a summary of the evidence received was published in March 1987 (Sinclair, 1987).

It is against this general background of concern about community care policy and practice that the King's Fund decided to take advantage of the rare opportunity afforded by the Griffiths review, and specifically Sir Roy's invitation to the Fund to assist him, to make positive suggestions about how the challenge presented by the present difficulties can best be met at all levels without major structural upheaval. For many years the King's Fund has been active in promoting and developing community-based care at all levels — from service developments at the frontline to policy formulation at local and national levels. This breadth of interest and experience is reflected in the report and in the conclusions reached.

The King's Fund Institute assumed lead responsibility for coordinating the exercise within the Fund and for preparing the resulting report which is distilled from work, either completed or in hand, at the College and the Centre for Health Services Development.

1. INTRODUCTION

'Managers do not solve problems: they manage messes'
(Ackoff, 1979, p100)

A version of this report was submitted to the review of community care being conducted by Sir Roy Griffiths. Given the King's Fund's involvement in community care issues over the past decade or so, Sir Roy invited the Fund to prepare for his inquiry a report on how successful innovation in the sphere of community care can be implemented in particular contexts and on what needs to happen for change to take root. In addressing these issues, the report draws extensively upon the knowledge and experience of the King's Fund in the community care field gleaned over many years of development work (see Appendix 1 for details of membership of the King's Fund Community Care Group). As part of this exercise, the King's Fund College invited a group of 34 senior managers from the NHS, social services and the voluntary sector to meet and review current organisational frameworks and processes for delivering community care. A summary of the main points from the discussion is provided in Appendix 2.

In order to keep the report to a manageable length, much detail has of necessity been omitted. However, full references to relevant sources and examples of innovative practices in which the King's Fund has had a hand are given to aid follow up. The work of the Fund has embraced each of the four main priority groups: mentally handicapped people, mentally ill people, elderly people and physically disabled people. The examples cited are drawn from all of these. We have not sought to address the needs of particular care groups separately, although we are well aware that their needs are sometimes quite different demanding in return a different service response. Instead, we have opted to emphasise the common concerns shared by the priority groups.

The report seeks to address two main concerns. First, while it is, and will always be, important for community care services to remain dynamic and improve on the way they meet client need, we already know what good services look like (their key features are briefly rehearsed in section 2 below). The challenge is achieving the spread of those good services. Currently they tend to be small scale, geographically isolated and add-ons to mainstream provision. Future policy at both national and local levels needs to be directed towards integrating such schemes into mainstream service provision across the country without sacrificing quality of care.

Second, our emphasis is on process change rather than structural change in the belief that an overriding concern with the latter could run the risk of undoing much valuable work that has already been achieved. Moreover, structural change on its own will not resolve the matter of the principles and objectives which should underlie community care. We are convinced that in the development of community care there is no 'organisational quick fix' that can be universally applied. In this regard we depart somewhat from the Audit Commission's apparent preference for structural change on a grand scale. We remain sceptical of the claims made for major organisational change (eg the creation of community care agencies) while having considerable sympathy for changes which seek to build on current innovative arrangements (eg developing the care manager role). Indeed, we believe that the Commission's more radical suggestions for structural change do not flow naturally from its diagnosis and may fail to resolve the problems to which it so eloquently draws attention. We elaborate on our views in section 3.

Given the central challenge we have highlighted, our purpose in this report is to identify the essential preconditions that will permit (a) the spread of good practice and innovative schemes, and (b) their subsequent take up and implementation as part of mainstream provision so that what is already being achieved on a small scale for the few may be achieved on a large scale for the many.

The report is in three main sections following this introduction. **Section 2** sets out what we believe constitute the essential components of community care provision. **Section 3** considers ways in which the challenge we have identified above may be met by strengthening financial and organisational incentives. Finally, **Section 4** reviews the implications of our analysis for national policy in the sphere of community care.

2. COMPONENTS OF COMMUNITY CARE PROVISION

The past decade or so has witnessed the gradual clarification of the basic elements of good community based provision. Developments have been most rapid in the field of mental handicap largely for reasons to do with the relatively small size of this care group and a growing acceptance of their needs being essentially social rather than medical. There has also been progress, albeit more limited, in respect of mentally ill people and, more recently, elderly mentally infirm people. However, because mental illness covers such a wide range of conditions it is difficult and probably inappropriate to devise a single solution for this care group. Some progress has also been made in respect of physically handicapped people and the frail elderly although there often remains no coherent philosophy and considerable service fragmentation.

The essential components of good community care services are the following:

Clear values and principles about what community care services are trying to achieve. For an organisation to be 'value-driven' is one of Peters and Waterman's (1982) eight attributes characterising innovative companies. There are key principles of service design which we argue should underpin effective community care services. In the mental handicap field these are the principles of normalisation articulated, *inter alia*, in the Jay report on mental handicap nursing in 1979 and in the King's Fund's ***An Ordinary Life*** published in 1980. Principles are an essential prerequisite to service development because they give everyone involved in their development a vision coupled with a real sense of purpose and direction. Principles for mental handicap services have been articulated more clearly than for services for people who are physically disabled, mentally ill, elderly or some combination of these. Significantly, too, and possibly not unconnected, service developments in the community for mentally handicapped people are much more advanced. It should be emphasised that the principles of good community care which the King's Fund has identified in ***An Ordinary Life*** and elsewhere (The Prince of Wales' Advisory Group on Disability, 1985; King's Fund, 1986) are not an abstract list of conditions but have been widely discussed with those planning and receiving services on the ground. Moreover, they have been incorporated into a number of planning strategies adopted by local agencies, notably as a guide to region-wide initiatives in Wales and North Western RHA.

Serving the interests of individual clients and recognising that they are the best spokespersons for their needs. This represents a move away from 'welfare paternalism' and towards client determined provision. For instance, the keywords underlying ***An Ordinary Life*** are: choice, consultation, information, participation, autonomy.

Harnessing developments in professional knowledge and techniques to meet clients' needs. In the mental handicap field, for example, this would involve applying behavioural approaches to assist clients in the realisation of their full potential.

Facilitating access to appropriate general opportunities and services provided by a variety of agencies including the NHS, education, housing, social services, social security, employment agencies, leisure services.

3. MEETING THE CHALLENGE

We stated above that the challenge confronting the development of community care services was twofold, that is, identifying the essential preconditions that will permit (a) the spread of good practice and innovative schemes, and (b) their subsequent take up and implementation on a large scale.

Innovation

We have already established that there is no lack of innovation in community care provision. The difficulties lie in its uneven spread, its small scale in terms of coverage of the client group involved, and its isolation from mainstream activity. A number of intermediate agencies have sought to disseminate knowledge about various initiatives but their efforts often go unacknowledged or are themselves somewhat sporadic and unsystematic. In addition, the resources of such bodies often only enable them to provide information on innovative schemes when what may be required is some means of assisting providers and/or agencies actually to adopt and implement new ways of working or doing things. For people with a mental handicap, bodies like the National Development Team for Mental Handicap, the Independent Development Council, and the British Institute for Mental Handicap are all active. For mentally ill people, there is the Good Practices in Mental Health project, the Health Advisory Service and the King's Fund the last two of which are also active in service development for elderly people. In addition, the Social Services Inspectorate reviews activities in the personal social services. These various statutory and non-statutory agencies have been important change agents by spreading the word about innovative schemes and good practice through publications, courses, mutual aid, field development work and through establishing and servicing networks of individuals providing and using services.

An important issue, to which we return in section 4 below, is the extent to which such activities might be enhanced. Certainly, the existing efforts of these, and other, agencies need to be acknowledged and supported but attention also needs to be given to ways in which their developmental work in particular might be given more emphasis in order to maximise opportunities to work with local groups in an attempt to secure change. We believe that the need for intervention of this type is increasingly necessary as the pace of change has quickened and its scale has grown. Without careful advance preparation of the ground there is a very real risk that what passes for community care will in reality prove to be no more than a recreation of institutional care albeit on a smaller scale. Indeed, examples of just such a distortion of community care already exist as health authorities rush to close long stay hospitals and neglect the importance of articulating clear principles and attending to the other prerequisites we noted in the previous section.

Turning from the spread of good practice to its subsequent adoption by mainstream services, the Audit Commission identified six shared features which underlay the examples of innovation it investigated. These were:

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

Our own experience confirms the importance of these process issues but they need to be put in the context of securing large-scale change.

Local 'champions' of change. Defining the essential qualities of so-called 'product champions' is difficult and probably the precise mix will be different in each case. Individuals who become identified as 'champions' are to be found at all levels in an organisation or service and may even exist across agencies. For instance, there are examples of

successful projects which have benefited from the linking of key individuals of equivalent status and responsibilities in a number of agencies involved in planning and delivering community based provision.

If product champions are to succeed then certain criteria require to be met. Identifying enthusiasts with a burning idea is an essential prerequisite for change but is not in itself sufficient. For example, the power and influence such individuals are capable of exercising will be important determinants of success. Depending on the position of the product champion in the organisation, enlisting the support of managers is essential. Particularly for complex innovations (ie those embracing a number of agencies) and those requiring resources, the ideal combination seems to be workers on the ground who are committed to making change happen in combination with managers who are able to ensure that the idea survives.

There are drawbacks in an exclusive focus on charismatic individuals or product champions. As, if not more, important is creating the context in which such individuals can flourish. The downside of charisma is dependence — individuals come to rely on the charismatic leader or innovator and neither feel ownership for, nor fully contribute to, the new service. An innovation in such instances only succeeds while its charismatic progenitor remains. Hence the necessity of an organisational climate that is value-driven and which enables innovations to survive and develop after their founders have moved on. Service ideals to which both innovations and mainstream services relate make it much more likely that innovations will be integrated into mainstream services rather than remain as precarious and vulnerable add-ons.

A second difficulty concerns the preparation of a cadre of individuals who might assume the change agent role. Currently, such individuals surface and acquire their knowledge 'on the job' using local professional and other resources to put together new service combinations. There is no established body of knowledge or training to equip people with the appropriate skills for such brokerage tasks although some developments in unit general manager training offer promising lessons. There is sufficient knowledge around the system resulting from numerous innovative schemes but it needs to be brought together, made more widely available and acted upon. Perhaps these are tasks for the development agencies we mentioned earlier and to which we return in section 4.

Focus on action. Decision-making procedures can be time-consuming and complicated in statutory organisations. There are, however, examples within health and social services of strategies which have been employed to overcome or minimise such difficulties. Most of these mechanisms involve the delegation of responsibility and resource management either to local management teams or to specific projects or individuals. Instances of locality or patch working conform to such a model. Such developments merit encouragement and support. In addition, there is scope for learning from the many naturally occurring experiments already in existence.

Locally integrated services. Innovative schemes are often the result not of the outputs of joint planning at strategic levels between health and local authorities but of the efforts of frontline providers to collaborate. Developments at this so-called micro level — which may be termed joint working to distinguish it from joint planning — are clearly important but are no substitute for devising and agreeing an overall strategy for service development within which to locate these specific developments. Otherwise innovative schemes will remain small-scale, isolated and fragile.

Focus on the local neighbourhood. This not only refers to decentralised management (patch or locality led development), but also includes consulting the people within a neighbourhood or encouraging them to participate in the planning and provision of health and social support services. Numerous schemes exist to bring planning down to the frontline level and to make it sensitive to user preferences (**examples 1 and 2**).[1]

While neighbourhood projects are of value they may be unnecessarily small in scale and limited in coverage. For example, the Crossroads care attendant schemes, of which there are over 100 across the country, provide valuable respite for the carers of disabled people but are often limited in size and coverage. It is entirely appropriate that such schemes be organised on a neighbourhood basis but their

1 All examples can be found on pages 18 and 19

coverage might be extended to cover a whole local authority area. This is another instance of where innovative developments need to be integrated into mainstream provision. If left as small scale schemes coexisting alongside main services, then it is unlikely that their coverage will be greatly extended even when this would be desirable. Moreover, small scale services are vulnerable to, and easily beset by problems arising from, staff absences through sickness or vacations.

The thrust of current thinking in community care planning and management is to decentralise (**example 3**). In fulfilment of such a philosophy there is patch based social service management, and patch or locality based health service management. It is essential that these decentralised arrangements do not get out of kilter giving rise to parallel rather than joint planning. Flexibility at local level is desirable but not at the cost of poor coordination or service quality. Moreover, as Dalley (1987) has observed from her King's Fund development work in NHS community units, while as a model a decentralised unit is a neutral notion it exists in reality in a value-laden environment where competing values and pressures abound. Such a complex environment does provide opportunities for managers committed to innovative service developments although they may profit from support and incentives. We consider some of these later in this section.

Team approach. Multidisciplinary working is vital in developing community care services as a plethora of projects have demonstrated. However, most teamwork is centred on professionals and there is a case for arguing that models of teamworking which strive to relate more closely to consumers of care and/or their carers should be investigated (**examples 4 and 5**).

Partnership between statutory services and voluntary organisations. Notwithstanding the importance of the voluntary sector it cannot realistically be seen as a replacement for state provision. There will always remain a role for government although this does not mean that all services need or should be provided by the statutory sector. Where government does not directly provide services it has a continuing responsibility to remain involved in their funding and, increasingly, their regulation and maintenance of standards (see, for example, Day and Klein, 1987, a, b)

A variant on the notion of partnership is the relationship between professionals and informal carers. Health and social services providers have traditionally in their concern with clients not always been attentive to the separate, and often different, needs of informal carers. If community care is to be based on partnership not only between various agencies but also between these and the community then there needs to be a negotiated style of service provision and targeting with professionals recognising the needs, rights and skills of both dependent people and their carers. The Disabled Persons (Services, Consultation and Representation) Act 1986 represents a partial attempt to enshrine in legislation such a reorientation in the relationship between statutory services and informal carers. Sadly, the Act awaits implementation with local authorities claiming that additional resources are necessary if the Act's provisions are to be fully implemented. However, much can be done within existing arrangements (**example 6**).

The Audit Commission claimed that innovations occurred despite rather than because of the system. It therefore sought to address the wider problem of how the system itself could be modified to enable innovative developments to become the norm rather than remain the exception. Perhaps surprisingly in view of its diagnosis and its examples of innovation which relied essentially upon changes in process rather than structure, the Commission regarded structural change in the shape of various combinations of service transfers between agencies as meriting further study.

The Commission identified what it termed three strategic options:

making local authorities the lead agency for providing care to mentally and physically handicapped people

locating a care manager for elderly people with a budget comprising NHS and local authority contributions and a joint board overseeing the arrangement

for mentally ill people either the care manager concept was an option or the NHS could assume responsibility for all services.

It is not part of our remit to comment on these options in any detail since that task is being undertaken by others. Nevertheless, based on our experience, we are convinced that any major organisational changes or redrawing of agency or service boundaries will achieve little unless these changes emerge naturally from local experience. To impose a uniform structure from the centre is likely to fall short of expectations.

At the same time, innovation does not just happen — it has to be made to happen. Organisational altruism may not be completely absent but it is not a sound basis for a policy. The need for incentives is therefore an important issue particularly in the drive to foster developments in community care on a larger scale. We are concerned principally with two types of incentive: financial and organisational.

Financial Incentives

There is nothing new about financial incentives to aid developments in community care although there are issues to be addressed governing their appropriateness. Joint finance has, since 1976 in England, been a source of pump-priming funds to stimulate collaborative activity between health and local authorities. In addition, a variety of central initiatives, like the care in the community programme, have also been designed to encourage innovative developments by making available earmarked sums for the purpose. These initiatives are bedevilled by numerous problems including the short period of funding (usually three years in the case of central initiatives) allowed, the lack of clarity about objectives, and the purpose to which such funds are put. Also, in the case of projects supported through joint finance, local authorities increase the risk of being rate-capped once they pick up the tab at the end of the tapering period. Under the present block grant system, local authorities stand to lose between £3 and £4 in grant for every additional £1 they spend. It is anticipated that the new community charge which will replace local rates will further penalise local authorities.

More recently, an unexpected financial incentive of a more long-lasting nature has been discovered, that is, the social security board and lodging allowances. This has served as a double-edged weapon. Insofar as the allowances have fuelled the expansion of private residential care — some of it of dubious quality — they have distorted the attainment of genuine, ie non-institutional, community care. However, in a few instances the allowances have been used in an enlightened manner and have offered a real incentive for inter-agency collaboration. Agencies have discovered that through collaboration they are often able to obtain access to larger overall budgets derived from a variety of sources than would be the case if they operated independently. Moreover, the mixed sources of financing which contribute to these agencies' overall budgets give them a degree of flexibility that is often not found within a single authority.

Of course, a consequence of obtaining access to a variety of financial sources is the adoption of organisational forms which increase complexity and add to the difficulty of maintaining public accountability. However, the problems are not insuperable if an individual manager is made responsible for coordinating such arrangements and held accountable for performing what amounts to a brokerage role. Wherever the boundaries are drawn, community care provision will remain a multi-agency activity for which there is a need for brokerage roles in their effective management.

An illustrative example of the enhanced revenue raising capacities might take the following form (all the sums mentioned refer to those available for one patient for one year):

- a £12,000 dowry from an RHA to its DHAs following the discharge of a patient from a long stay hospital into the community
- an extra £1,500 obtainable through housing associations and the various grants for which they are eligible
- another £2,000 arising from board and lodging payments in unregistered homes
- or possibly up to £6,000 for board and lodging payments in a registered home.

Revenues raised by such means can then be used to provide individually tailored packages of care which might involve a combination of public, private and voluntary provision.

An example of the type of collaboration to which such opportunistic revenue-raising can give rise is provided by

the Southwark Mental Handicap Consortium (**example 7**) but there are at least in the region of 20 to 30 other arrangements around the country operating along similar lines. In each case the motivation for collaboration has arisen from the desire to pull together packages of funding from several sources.

Change in the current deployment of board and lodging allowances is virtually certain in the light of the Firth (1987) report although whether the joint working party's favoured option — that all public funding of residential care should become the responsibility of local government — will find favour is uncertain. The point we wish to stress, however, is the importance of the resource pool created by the board and lodging allowances serving as a potential incentive for collaborative working between health and local authorities in the development of community care. Much of this development has taken innovative forms. Our concern is that if this incentive is to undergo modification or disappear altogether then attention needs to be given to a source of funds which would both enable continuing development in local services and promote collaborative working.

Organisational Incentives

Organisational incentives are required at two levels: the local level of inter-agency collaboration, and the frontline level of service delivery. There are many examples of authorities up and down the country where organisational fragmentation serves to undermine an effective community care strategy and to sap the energy of those endeavouring to make it work. It is not uncommon for a DHA to have to relate to several local authorities. Before any attempts can be made to develop detailed proposals, fundamental problems arise in resolving matters of accountability and responsibility and these are often sufficient to halt progress. Hence the value of consortia and other arrangements (see below)

At the local level we believe three key principles are of importance:

- fostering social entrepreneurship among enthusiastic and committed managers

- delegating policy objectives to enable managers to exercise their discretion and negotiate appropriate responses to opportunities that arise

- encouraging flexible and innovative forms of organisation in the delivery of care at the frontline.

Drawing on the King's Fund's project development work and on other successful initiatives like the Kent Community Care project for frail elderly people (and its offspring in other parts of the country), two principles are of importance at frontline level:

- the need for case management, ie a recognition that an identified individual — case manager or key worker who could be any one of a number of professionals — must have responsibility for coordinating the support received by individual clients

- the need for flexible budgets and price information to permit the assembly of individually tailored care packages.

Devising a system of inter-agency collaboration is essential in respect of all the priority care groups although the precise balance of input from the various participating agencies will differ according to the particular care group in question. Even for mentally handicapped people, there will be occasion for health services to be involved. Bureaucratic inflexibility is the antithesis of collaborative working which is the essence of good community care. Although models of joint working cannot be imposed on agencies, there is a strong case for enforcing the *principle* of collaboration by developing review processes which focus on joint plans as South Western RHA (in collaboration with the relevant local authorities) has been attempting. This might be combined with a commitment to positive monitoring to ensure the development of services in the desired direction.

Much of any monitoring or evaluation would, of necessity, be of a process or intermediate nature. That is, the work of new organisational arrangements would be assessed not only by focussing on *what* was being done (and with what effect as far as this could be ascertained) but on *how* it was being done so as to aid policy and organisational learning.

As we have noted, the issue of accountability in collaborative working is frequently raised as presenting a

problem. However, this becomes less of an issue if it is established at the outset that no collaborative scheme can proceed without the active support of each participant within a collaborative framework each of whom is answerable to his/her own constituency whether it be local authority members, health authority members and so on.

Joint planning cannot succeed without forms of management collaboration. A distinction can be made between collaborative management practices on the one hand, and organisational forms on the other. It is the model of collaboration that is important and which needs to be applied generally while accepting that the particular arrangements adopted will display considerable local variation.

Joint planning on its own has proved largely ineffective as a means of securing community based care which draws on the experience and commitment of all interested parties. The Working Group on Joint Planning's report, ***Progress in Partnership***, published in 1985, is the latest in a long line of critical statements. Clearly, current joint planning machinery is insufficient to ensure progress at the level of implementation. A firmer commitment to collaborate in the management of joint plans is required.

An example of a collaborative organisational form is the notion of a consortium. The Southwark Mental Handicap consortium has already been mentioned as an illustration but there are many other examples (**example 8**). The schemes all have one major feature in common, namely, they are not generally concerned with a joint planning process but rather with the response to that process — that is, how do we actually get things done.

Consortia do not represent the only solution to the problem of implementing jointly agreed plans — there is in any case no 'single bullet' solution as Sir Roy pointed out in his letter to the Secretary of State on general management — but they are one means of achieving this goal.

Crucially the consortium provides a forum which allows the nurturing of a common perspective and provides a counterbalance to the individual strategies of the participating agencies. This singular lack of a forum for such a purpose has been identified as a serious gap in much of the King's Fund's project work. In situations where custom and practice predominate there may be no forums in which managers can seriously address community care issues.

A similar situation prevails in primary health care a sector which, for a variety of reasons, has never been systematically planned. Indeed, there is a complete lack of a planning tradition with the result that a policy vacuum exists with no clear policy direction in evidence. Custom and practice become substitutes for policy. For most areas of primary care, including its contribution to community care, neither DHAs nor FPCs have clear policies that are known and understood up and down (and across) the structure. There is no forum for the discussion of policy or its implementation. Consequently no agendas for collaboration exist. It has been the task of King's Fund development workers to attempt to tackle these omissions with varying degrees of success.[2] The basis of this work, which is time-consuming and demanding, is not the imposition of solutions on agencies or participants but on encouraging them to take responsibility for devising and effecting their own solutions.

2 *Development work is in hand in primary care settings in Tower Hamlets, Camberwell and Liverpool. In Tower Hamlets, the project steering group is the only forum where representatives from all the relevant agencies sit down together*

4. IMPLICATIONS FOR NATIONAL POLICY

Section 3 has centred on the activities of health and local authorities, voluntary bodies, service providers and service users (including carers) but there are many implications in what has been said for the way in which central government operates and relates to field agencies. The local arena can only artificially be separated from the activity or inactivity of the central arena in facilitating community care. If examples of innovative service development at local level are not to remain isolated one-off occurrences then there is an obligation on central government to assume responsibility for ensuring that the principles of policy development in community care are widely accepted and seriously addressed. Within these limits there should be maximum local autonomy for devising the precise organisational and managerial arrangements to realise the principles.

The tasks for which only central government, with the DHSS assuming a lead role, is equipped are the following:

Creating a framework for the development of community care services, ie by establishing clear principles about what community care services are trying to achieve, and to provide inspiration and act as a spur to service managers and providers possibly in ways we cited earlier. This is an essential precondition for creating the climate in which innovation can occur.

Fostering cooperation among central departments, in particular with the Department of the Environment. Exhortations to health and local authorities and voluntary agencies to collaborate do not appear to have their counterpart in Whitehall. With the demise in the late 1970s of the former Central Policy Review Staff's (1975) Joint Approach to Social Policy initiative little attempt has been made to address the problem of departmentalism and the contradictions in policy which are a feature of it. Perhaps this is a task for both the Supervisory Board and Management Board to pursue.

Introducing a system of bridging finance, perhaps through RHAs, to allow community services to be developed during the 'hump' period, that is, the transitional phase of running down and eventually closing long stay institutions. Part of this could take the form of a 'loan' payable from the proceeds of the disposal of institutions. The establishment of a development fund through top-slicing the NHS Vote and local government RSG would also assist in the development of alternative services. Such a fund would compensate for resources still tied up in existing services. Funding would continue for an agreed period until resources were released from the termination of existing services.

Giving a lead on the matter of new patterns of working for professional staff. For example, the proposals for a new caring profession in mental handicap services produced by the Jay Committee in 1979 were rejected by the government and the UKCC and CCETSW have yet to agree a new form of basic training. New developments in primary health care raise similar issues.

Facilitating the transfer and deployment of staff between the NHS and new community care services. Guidance for health and local authorities is required on staff terms and conditions as they make the transition from one service to another.

Investing in development agencies for the priority groups on a scale commensurate with the scope of the transition from institution based to community based care.

A model for most, if not all, of the items listed above can be found in the Welsh Office's All Wales Strategy for the Development of Services for Mentally Handicapped People which is now entering its fifth year of a 10 year programme. The development of the Strategy, and its departure from what is happening elsewhere in mainland Britain, has been documented most recently by Hunter and Wistow (1987). A review of the Strategy's progress since 1983 has been completed by the Welsh Office (1987). There are, of course, differences in the scale and complexity of the Welsh Office compared with Whitehall but the point to stress is

the political commitment from the former Secretary of State for Wales and the commitment from his officials and advisers to a vision and a new model of service development which has firm foundations in a clearly articulated set of principles coupled with flexibility over their implementation.

The All Wales Strategy demonstrates a number of the key features required to foster a climate in which the transition to community care can take place. It is important to stress that the Welsh Office has taken a clear lead in establishing these features. They comprise: a set of principles governing service development for mentally handicapped people and a commitment to involving service users, their advocates and relatives in shaping the new services; the availability of additional resources to secure the implementation of alternative provision in advance of hospital closure; giving a lead responsibility to local authority social services departments to take the initiative at local level; identifying two vanguard areas which would experiment and innovate ahead of other areas in order that any lessons to be learned could be picked up and passed on; identifying training in its broadest sense as a key contribution to development and establishing a Training Support Unit; and building in independent evaluation of the Strategy as it evolved. From the start the Strategy was regarded as an exercise in policy learning for all involved. Modest claims were made for it and the Welsh Office accepted that there were no 'right' answers or organisational 'fixes'.

The Strategy, suitably adapted, provides a possible model for service developments in other care groups. To date, the Welsh Office has begun to address the needs of elderly people in the community drawing on the model adopted for the Mental Handicap Strategy.

In England, there are a few examples at RHA level (eg North Western and South Western) of strategies being set out as a basis for the planning and development of community services. In North Western RHA, for example, a clear set of service principles has been articulated based on the King's Fund's ***An Ordinary Life.*** The elements of a model district service have been identified and DHAs' plans are expected to conform to this model. From the outset, developing a genuine joint approach with local authorities has been a central feature of service development.

We believe that the DHSS should insist upon similar action being taken by other regions using the performance review machinery to monitor progress although this will require the Department itself giving consideration to how local authorities' views can be incorporated.

5. CONCLUDING OBSERVATIONS

We believe that the central challenge facing the future development of community care services is to ensure that the models of good community care and innovative ways of working which the Audit Commission and others have identified do not remain isolated and fragile showpiece initiatives but become integral to mainstream provision.The overdue transition from small-scale experimentation to large-scale community care service development can only succeed if certain preconditions are established and if incentives are available to hasten progress where necessary (Towell, 1987).

The starting point, as in any endeavour, is the need to clarify and be explicit about the values and principles underpinning service development if the necessary vision and commitment from all interested parties is to be secured. All meaningful innovations have this much in common. Without clear and agreed values and principles, service development will remain piecemeal and ad hoc. At best, new developments will remain add-ons to mainstream services which will not meet the central challenge we have identified.

Once values and principles have been agreed, attention can then be focussed on the means to operationalise them. The means must embrace financial, organisational and managerial arrangements at all levels: national, local, and frontline. There is a need to create at national and local levels an environment that is supportive of innovation and change in community care, and to devise at a frontline level organisational forms which will allow case management and budget flexibility to operate in a multi-agency setting so as to free up the way in which resources — financial and human — are deployed.

Derived from our collective experience over many years of research and development work covering all the priority services, we favour a policy and organisational learning approach in the future development of community care building upon what already exists rather than opting for a wholesale reorganisation of services with all the disruption and costs which will inevitably be incurred. Organisational change flowing from particular local circumstances and preferences is a quite different matter from change which is centrally and uniformly imposed. In a setting like community care where there is no 'one best way' or 'right' answer there is merit in diversity and experiment provided mechanisms are in place to aid learning from these varied experiences. We remain convinced that embarking on a major centre-led, or Regional Health Authority-led, restructuring of agency boundaries and organisational relationships will fall short of expectations and will fail to tackle the crucial process issues which in our experience provide many of the impediments to progress. The option of structural change should, however, be kept open where the new incentives to develop services fail.

Many of the process issues may seem unglamorous but the need to provide professionals and users with forums to debate policy and service matters, to provide basic information on what services are available and the gaps which exist, to support potential champions of change and ensure that their actions are 'owned' by all those involved cannot be underestimated. At the same time, work of this kind seems to offer the best hope of real and sustained progress in the longer run provided it receives support and commitment from senior managers and from government.

For effective policy and organisational learning to occur, there is an important and hitherto insufficiently acknowledged role for development agencies like the Health Advisory Service and the National Development Team for Mentally Handicapped People. Indeed, we believe there is a sound case for expanding and strengthening the development activities of these and other bodies both in the statutory and non-statutory sectors.

In much of what we have said there are implications for the way in which central government relates to local agencies. We believe that if overdue changes in the development of community care services are to be effectively secured then the responsibility has to be shared between the centre and the localities. The attempt in Wales, through the All Wales Mental Handicap Strategy, to redefine the centre-periphery relationship is an indication of what might be achieved and provides a possible model for adoption elsewhere in the UK.

Selected illustrative examples

Example 1

One such scheme is operating in Pimlico (Riverside Health Authority) where a committee of local residents, voluntary sector representatives and health and social service professionals has been set up by a project development worker to look at what the area has and what it needs in respect of community health services. The committee has already become a forum for information exchange about what services are available, and for discussing gaps in services and how they might be filled.

Example 2

Another consumer-led initiative is the City and Hackney Multi-Ethnic Women's Health Project (see J Cornwell and P Gordon (eds), ***An Experiment in Advocacy: The Hackney Multi-Ethnic Women's Health Project***, King's Fund, 1984). Set up in 1979 to improve access to the NHS for non-English speaking women during their pregnancy and childbirth it has become a successful experiment in helping the NHS find ways of listening to the needs of users and changing to meet those needs. Its initiatives have expanded to include community clinics, the DGH and children's hospital. The project's steering group consists of half NHS and half community representatives. Project workers act as user or patient advocates. A strong steering group has been necessary in overcoming initial professional resistance. The day-to-day manager and budgetholder is the CHC Secretary. A management group representing the CHC, the local Council for Racial Equality and the Health Authority oversees the project.

Example 3

The decision to decentralise child health services in Newham Health Authority has been documented by the King's Fund Primary Health Care Group. Clear lessons emerged about the implementation of change in community health services. In particular, formal, multidisciplinary planning groups, active and regular consultation with staff and a structured training/introduction plan all contributed towards the effective coordination of change (see L Winn, ***Coordinating Change in Child Health Services: the experience of decentralisation in Newham health authority***, King's Fund, 1987).

Example 4

The Wells Road Service in Bristol is a small scale local service for people with learning difficulties. Staffed initially by two community support workers, a specific objective of the project was that the community workers would liaise with carers and the local community. The Wells Road Service has provided lessons on interprofessional relationships and roles.

Example 5

Greenwich Centre for Independent Living (CIL) is one of the handful of examples of a new development in Britain. CILs exist to help ensure that physically disabled people have a say in planning their own services. Their aims encompass advocacy and achieving a consumer voice for disabled people in the planning and implementation of services. CILs act as 'brokers' to aid physically handicapped people living in the community in achieving the mix of services best suited to their particular needs. They may also act as local advocacy and support groups concentrating on access and transport issues. CILs are all locally based; some receive joint funding, others are funded by local authorities (see ***Centres for Independent Living in the US and UK — an American Viewpoint***, Report of a Seminar, King's Fund, 1984).

Example 6

An example of the attempt to foster partnership in service provision is the Caring Together scheme in Stockport. The project, funded by the DHSS under its 'Helping the Community to Care' initiative, aims to bridge the

statutory services and informal sector by funding small scale initiatives. A consortium of statutory and voluntary organisations (which includes informal carers) manages the project.

- to provide a framework within which all the constituent bodies can work together to develop staffed houses for people with a mental handicap

- to offer a continuing forum in which issues of common concern around the development and management of services for people with a mental handicap can be addressed and worked on jointly.

Example 7

The Southwark Mental Handicap consortium has been in operation for two years. It comprises the two health authorities covering Southwark, Southwark social services department, local voluntary organisations, the Southwark adult education institute and three housing associations. The consortium has two major purposes both centred on implementation rather than planning and stemming from the need to provide community provision for people discharged from Darenth Park hospital which is scheduled to close at the end of 1987:

Example 8

A consortium of a rather different kind is the Camden Consortium. It was initiated by the CHC in response to closure plans for Friern hospital and is made up of users, voluntary organisations' representatives and interested health and social services staff. Mention has already been made in example 6 of the Stockport consortium which has brought together statutory services and voluntary organisations.

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Appendix 1

King's Fund Community Care Group

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Appendix 2

KING'S FUND COLLEGE SENIOR MANAGEMENT GROUP ON COMMUNITY CARE: A SYNOPSIS OF ITS SUBMISSION TO THE GRIFFITHS REVIEW †

At the invitation of the King's Fund College a group of 34 senior managers from the NHS, social services and the voluntary sector met over three days in May and July 1987 to review current organisational frameworks and processes for delivering community care.

Participants examined the current and future roles of contributing agencies in meeting the overall objective of providing comprehensive community services for elderly people and people with a mental handicap, illness or physical disability.

The group reached the following conclusions:

- that the community care initiative should not be judged by the rate of rundown and closure of existing institutions but rather by the strength and continuity that can be established in building up appropriate frameworks of local community services
- that the government should restate its commitment to community care and indicate firm targets and timescales for the build up of community services for people with disabilities in addition to the rundown and closure of institutions
- that a national commitment to community care must clearly represent the values and principles that should underpin the development of local services.

These principles should emphasise the need for services which

- enhance individuals' presence in the community
- encourage the development of relationships between disabled and non-disabled people
- extend the variety and opportunities for choice
- support the personal development and competence of individuals
- value the citizenship roles of people with disabilities
- that the planning system be given the authority to demand local cooperation and include a formal approval system for any plans that are produced
- that a single national budget for community care be constructed centrally
- that the board and lodging budget be protected while at the same time ensuring its further use is secured through nationally and locally approved plans
- that the plans being developed by CCETSW and UKCC for the social work and nursing professions take full account of the integrated nature of providing care in the community
- that a central initiative be introduced to facilitate staff transfer between agencies
- that three options are available for addressing the problems posed by the way in which community care is organised
- extending the joint planning system
- establishing lead agencies
- creating new agencies
- that the need and scope for change at local levels, and therefore choice of options, would be determined by local characteristics and the ability of agencies to perform

† Copies of the complete statement, ***"Making a Reality of Community Care" — A Response to Sir Roy Griffiths and his Review Team***, may be obtained from Ritchard Brazil, King's Fund College, 2 Palace Court, London W2 4HS.

- that while structural change in the form of establishing new agencies will be costly and disruptive it may have significant advantages if, in the view of a particular locality, strengthened joint planning is insufficient to secure change

- that diversity and pluralism in service provision be encouraged while at the same ensuring the quality of services which will require investment in policy and organisational learning and development

- that a stronger central policy lead combined with service monitoring from the centre be supplemented by central dissemination of good practice.

KING'S FUND INSTITUTE

for health policy analysis

The Institute is an independent centre for health policy analysis which was established by the King's Fund in 1986. Its principal objective is to provide balanced and incisive analyses of important and persistent health policy issues.

The Institute's approach is based on the belief that there is a gap between those who undertake research and those responsible for health policy. Four major areas have been identified for the initial phase of the Institute's work.

Resource Allocation - Resource issues underpin virtually every aspect of health care and its provision. The Institute will monitor aggregate public expenditure trends as these affect health and personal social services, and undertake independent forecasting and the production of alternative scenarios. It will aim to assess the impact of cost improvement programmes and other value for money initiatives at the local level by working in collaboration with a small number of District Health Authorities.

Health Promotion - Health promotion has been on the government's agenda for at least a decade, albeit in a narrowly defined sense of the term. The production of a broad and critical review of health promotion policy will serve as a basis for identifying future policy directions and approaches.

Technology Assessment - The deployment and use of technology of one kind or another is central to health care yet its assessment is either partial or absent altogether. What is critical to modern health care systems is the evaluation of medical interventions to establish their safety, efficacy, efficiency and appropriateneness. The Institute aims to serve as a coordinating body to analyse and synthesise work in this field.

Priority Services - Care for the priority groups (older people, mentally handicapped, mentally ill and physically handicapped people) and developments in community care provide the initial focus for the Institute's work. Developing coherent strategies for the priority groups remains a challenge for government and society. It is a concern which touches all policy sectors, departments, levels of government and many non-statutory agencies. Numerous innovative schemes to promote community care have received official support in recent years. Evaluation studies of these are likely to have important implications for policy and for managing change in services.

The Institute has adopted a multidisciplinary approach and seeks to make timely and relevant contributions to policy debates. Conferences, seminars and workshops are an important feature of the Institute's activities; the intention being to raise the level of public debate and heighten awareness of health-related developments whenever they occur.

The Institute is independent of all sectional interests. Although non-partisan it is not neutral, and it is prepared to launch and support controversial proposals.

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