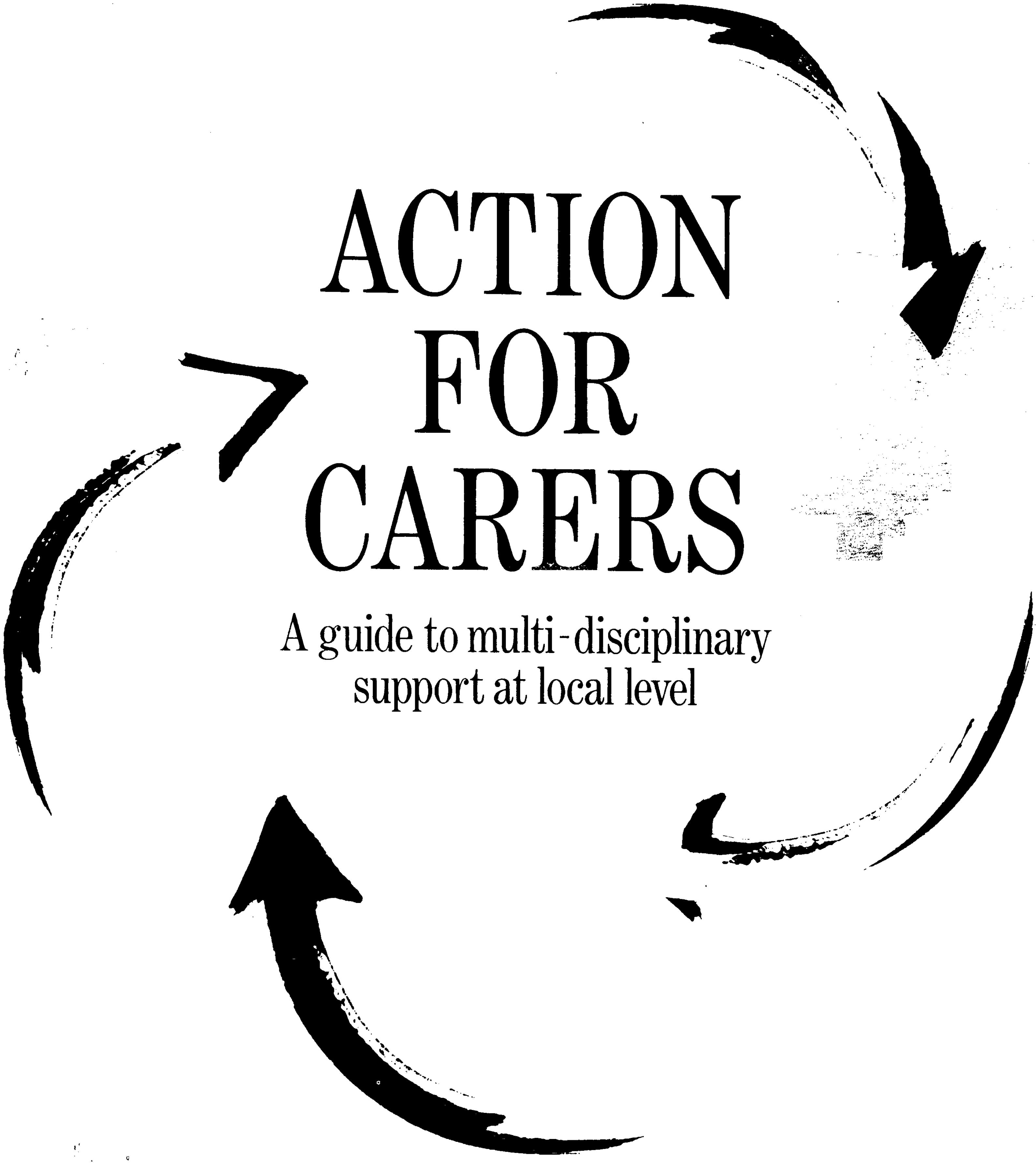


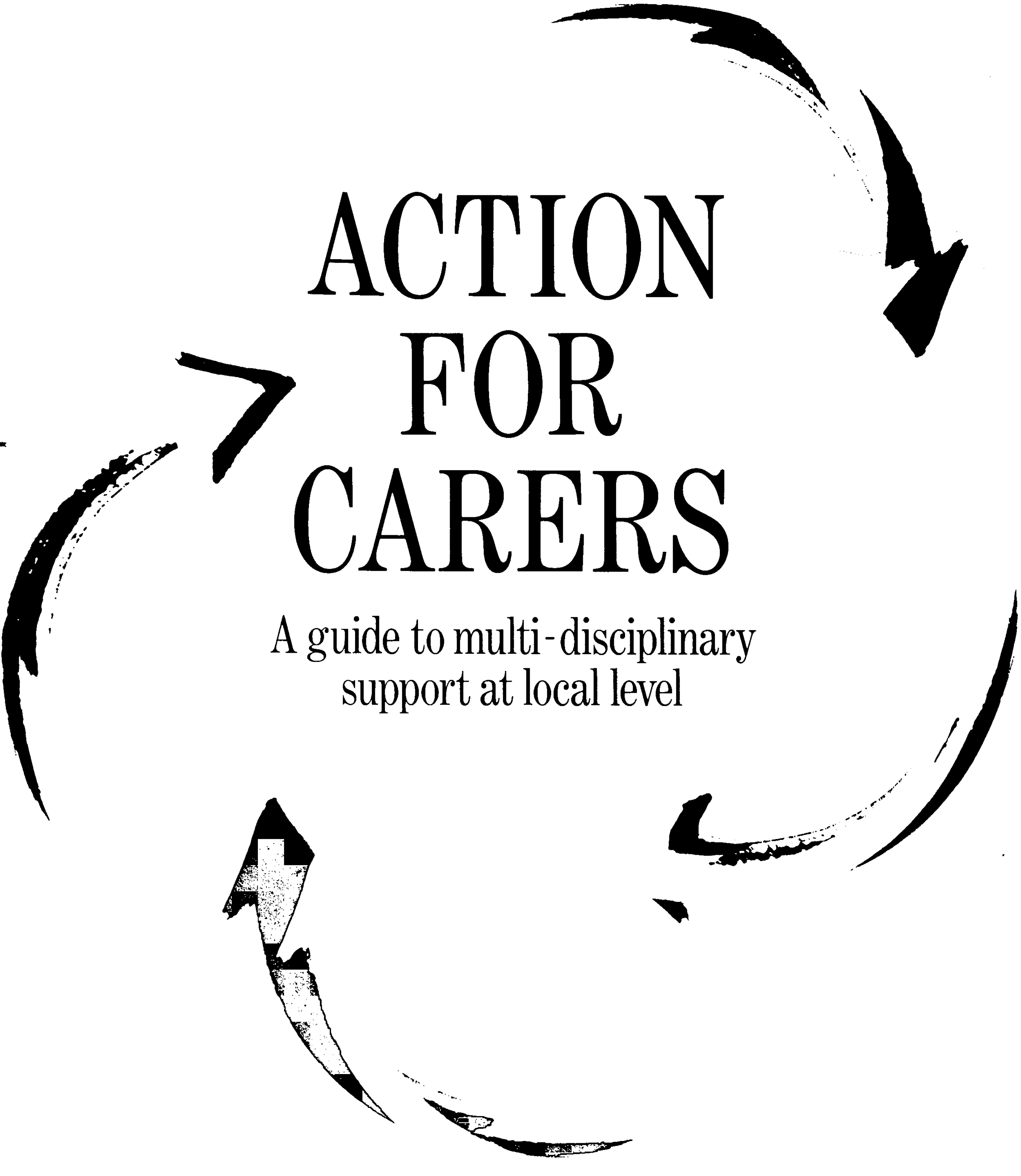
ACTION FOR CARERS

A guide to multi-disciplinary support at local level

HEALTH EDUCATION AUTHORITY

KINGS FUND Informal Caring Programme

LONDON BOROUGHS' TRAINING COMMITTEE



ACTION FOR CARERS

A guide to multi-disciplinary
support at local level

Package introduction

Acknowledgements

This package is part of a **London Boroughs' Training Committee** project commissioned by the **King's Fund Informal Caring Support Unit**, with evaluation by **The Department of Health and Welfare Studies, Institute of Education, University of London**.

Published by the King's Fund Informal Caring Programme with financial assistance from the Department of Health and Social Security and the Health Education Authority.

ISBN 1 870551 14 1

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The producers of this package are grateful for the immense time and commitment afforded to them by the very large number of people who took part in the Croydon project. In particular we would like to thank:
Anne Brown (Consultant Geriatrician, Croydon Health Authority)
Joyce Daniels (Executive Committee Member, Croydon Council for Community Relations)
Ronald East (Chairperson, Croydon Association of Carers)
Ravi Gavindia (Education Officer, Croydon Council for Community Relations)
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John Simpson (General Practitioner and member of Local Medical Committee, Croydon)
David Townsend (Director of Social Services, London Borough of Croydon)
Maja O'Brien (Project Coordinator in the design stage).

We are very grateful to the following who have read and commented on the contents of this package:
Lynne Berry (National Institute for Social Work)
Tessa Harding (Community Care Project, National Council of Voluntary Organisations)
Gillian Parker (Social Policy Research Unit, University of York)
Jill Pitkeathly (National Council for Elderly People and their Dependants).

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Introduction to the learning package

'Action for carers: a guide to multi-disciplinary support at local level' is a learning package aimed at improving the support given to carers by health, social service and voluntary sector agencies. It is based on a pilot project in Croydon.

The package describes ways in which more effective collaboration between agencies can be achieved and the impact this can have on improving support for carers. Emphasis is placed on joint working at different levels in the community – among practitioners and workers in defined neighbourhoods and among service managers and policy makers at an area wide level.

The package adopts an active approach to change. The emphasis is on finding strategies, structures and activities that will produce changes in the support given to carers in a particular locality.

The package consists of two booklets and a set of looseleaf learning Modules for use in practice development groups. These are listed overleaf.

Origins and development of the package

Carers are at the sharp end of policies for care in the community. Much still needs to be done to provide them with the support they need. A key issue in meeting the challenge carers present is the extent to which local authorities, health services and voluntary organisations can work together with carers to improve the level and quality of support available.

It was in this context that, in 1986, the King's Fund Informal Caring Support Unit commissioned the London Boroughs' Training Committee to design a development project that would improve inter-agency support for carers. The project was developed and implemented in the London Borough of Croydon, with the cooperation of local health and social welfare agencies and carers groups from the area.

The project was evaluated throughout by a team from London University Institute of Education. In the latter half of the project learning materials specialists were employed to transform the practical sessions and the lessons of the evaluation into a learning package that can be applied elsewhere. It is hoped that by offering practical guidance on the processes involved, and providing easily accessible and stimulating material for use in practical sessions, people in other areas will be able to mount similarly successful initiatives.

Contents of the learning package

Booklet 1 'Setting up and running a project' outlines the actions needed to establish and develop a project at both policy and practice levels and discusses the issues and problems that may arise during this process. The experience of the Croydon project is drawn on throughout and flowcharts and checklists are provided to make this section of the package a practical tool.

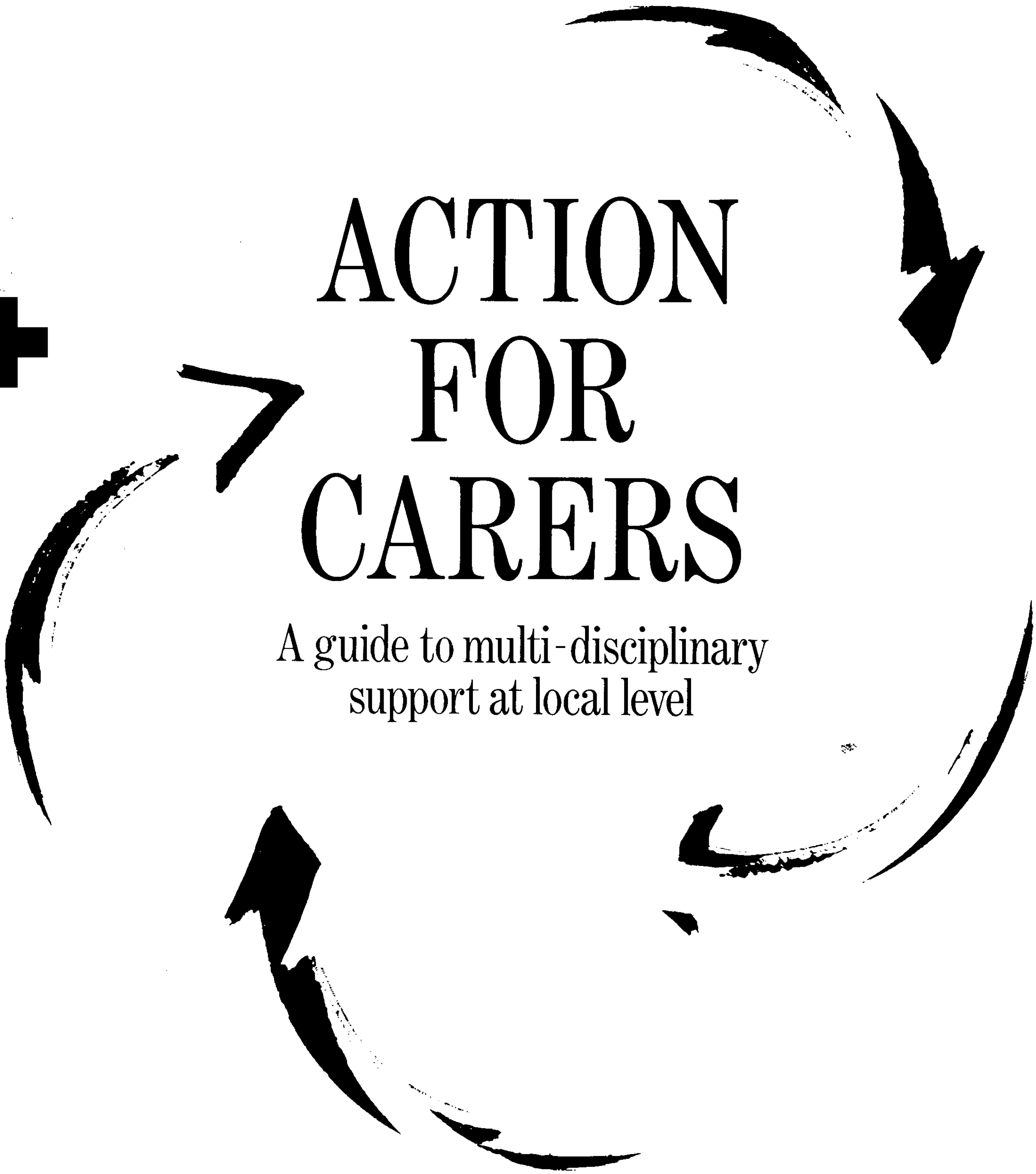
This booklet is likely to be most useful to the individual or small group of people who take responsibility for establishing a project, probably people in middle or senior management who have contacts across the agencies concerned with carers.

Booklet 2 'Group facilitator's guide to practice development' discusses the use of the learning Modules in practice development sessions with mixed groups of practitioners such as health visitors, GPs, social workers and voluntary workers. The aim here is to examine the needs of carers and the potential for improving support in the field through better collaboration.

The booklet provides basic guidance for those not familiar with running this type of group and raises specific issues that may need to be dealt with.

Looseleaf Modules 1–14 are for use in practice development sessions. They cover a range of issues involved in multi-disciplinary work in support of carers. They are supplied loose leaf so that a selection can easily be made and copied to suit the needs of different settings and groups. The areas covered by the Modules are:

Module 1	Introduction to 'Action for Carers'
Module 2	The experience of caring
Module 3	The needs of carers
Module 4	Identifying the carers
Module 5	The role of the worker with carers
Module 6	Offering emotional support
Module 7	Managing your work
Module 8	Collaboration
Module 9	Packages of care
Module 10	Communication
Module 11	Information
Module 12	Statutory/voluntary sector relationships
Module 13	Informal networks and neighbourhood care
Module 14	Implementing change



ACTION FOR CARERS

A guide to multi-disciplinary support at local level

Setting up and running a project

Contents

The consultation phase

Introduction

This booklet describes how to set up a project to develop inter-agency support for carers. Two alternative approaches are suggested: using a working party to organise and guide a major project, or adopting a small-scale incremental approach that can be handled by one person.

In order to decide which approach to take, some initial planning and sounding out will be necessary. Steps 1–5 in the flowchart overleaf describe one way of approaching this and could be taken by an individual or a very small number of people working together. As an individual this might mean an hour's desk work followed by three or four meetings or extended phone calls.

If a major project seems feasible then further planning and administrative work would be needed to set up the first meeting of a working party. Steps 6–10 of the flowchart draw on the Croydon experience to describe the processes a working party would need to go through in consulting in the field and agreeing a programme of development work. They could be carried out by a working party meeting regularly over a period of 3–4 months.

If a small scale or incremental approach seems more workable then only Steps 7 and 10 need be followed.

1 Identify the issues

This package is about developing a project that will support carers by improving the way people work together. Initiating such a project will mean at some point:

- examining your own assumptions and beliefs about carers and the caring role
- reflecting on the values that lie behind these assumptions and beliefs
- reviewing your knowledge of studies done of carers and their needs
- identifying suitable strategies and approaches for a project
- assessing support and interest and consulting other people for their views.

Each of these is taken up in more detail at various points in Steps 2–10 of the flowchart. To get started, it is enough to identify some key issues that a project for carers in your area might touch on, and some very broad aims related to these.

In your area, support for carers may or may not be an issue high on people's agendas. There may already be people actively concerned with the needs of carers or it may be an unknown, unheard of issue. Similarly, working together collaboratively to meet carers' needs may be remote or close to people's concerns. Contemplating a project about carers means finding out what are the 'live' issues that will make a project relevant and useful in a particular area.

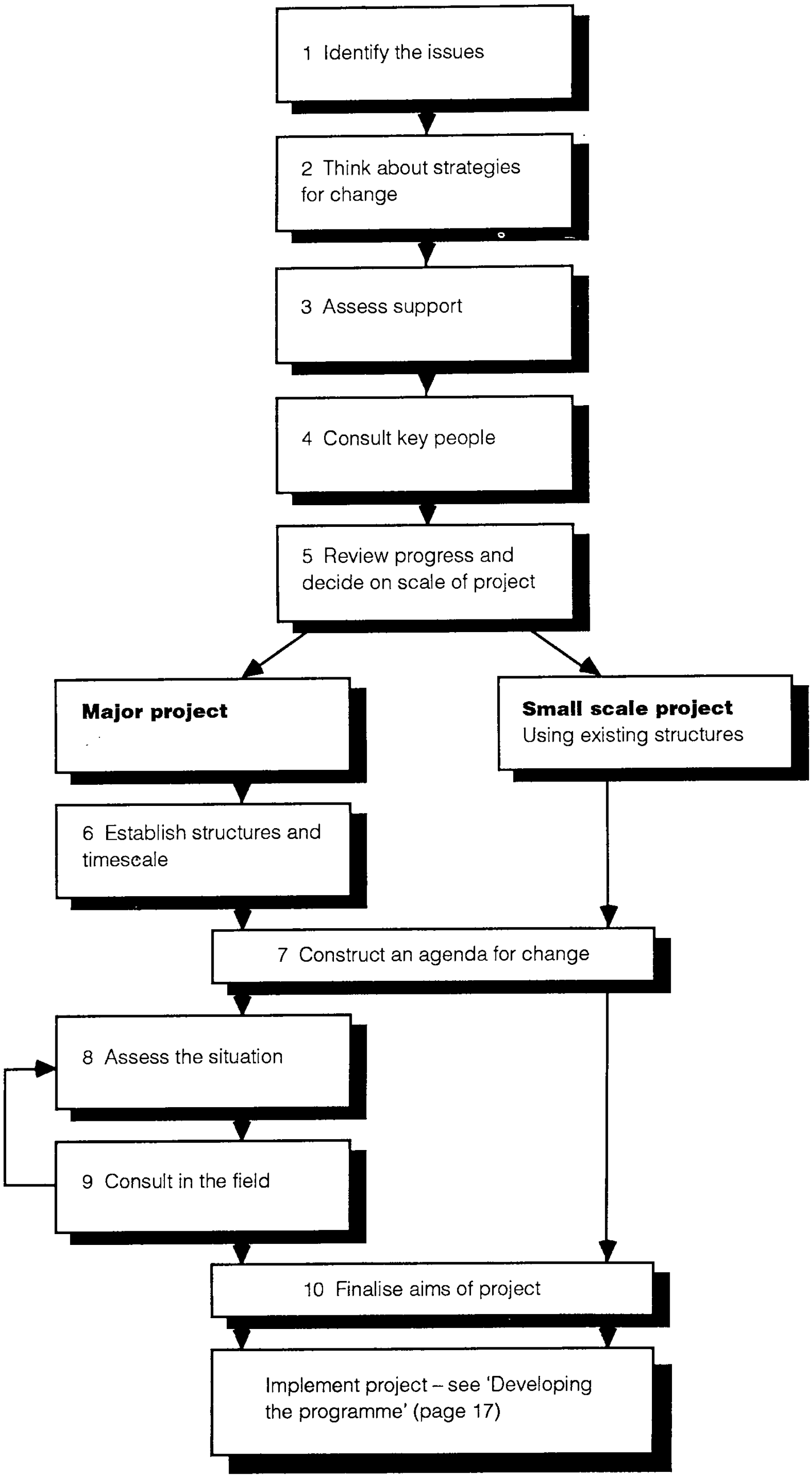
Start by trying to generate from your own knowledge and experience what such issues might be. It may be helpful to ask yourself:

- What local issues might a project about support for carers address?
- What problems might it try to solve?
- What might it try to change?

➢ In CROYDON for example plans were being made to close the local psychiatric hospital. The health authority was responsible for providing information to clients and relatives on how they would get help and support in the community. The proposal for the project fitted neatly with their need to discover what the needs of this group would be once they were living in the community. Aims that fitted this need were that the project should: 'identify needs for additional resources to support carers' and 'develop a greater understanding of different agencies and practitioners' different roles and functions in relation to carers'.

The year before the project, the Adult Services division of the Social Services Department had taken steps to move towards a more consumer based approach. They were now looking for ways of implementing this philosophy and hoped that the project might produce practices that would support it. Aims that fitted this need were that the project should:

- 'change attitudes towards carers amongst practitioners'



1 Identify the issues
2 Think about strategies for change
3 Assess support
4 Consult key people
5 Review progress and decide on scale of project
Major project
Small scale project
Using existing structures
6 Establish structures and timescale
7 Construct an agenda for change
8 Assess the situation
9 Consult in the field
10 Finalise aims of project
Implement project – see 'Developing the programme' (page 17)

- 'develop the skills and knowledge in practitioners to respond more effectively to carers'
- 'pay special attention to the needs of carers from black and ethnic groups'
- 'involve carers in the planning and development of the programme'.

A full list of aims of the Croydon project is given on page 11.

2 Think about strategies for change

The most effective strategy for change is often a *problem solving* one which involves, explains and allows people to 'own' the whole process. Less effective are strategies which use *authority and hierarchy* to tell people what to do, or which assume that *instruction based on common sense* will bring alterations in behaviour.

An example of the first type of strategy would be the request to a staff group to come up with proposals for supporting dependent people in the community, accompanied by a commitment to discuss and negotiate changes. An example of the second would be a centrally issued directive telling staff what to do to support people in the community. An example of the third would be the circulation of a paper to staff explaining the rationale behind the policy decisions management were taking over support for dependent people in the community.

Another way of looking at strategies is to ask whether they are '*top-down*', that is initiated by those in power, or '*bottom-up*', that is demanded and organised by people in the field. A top-down approach can seem efficient but may suffer from a lack of contact with those in the field and inadequate understanding of their problems. It may tend towards the centralised, hierarchical model or to the 'they'll-do-it-if-they-know-the-reason-why' model. A bottom-up approach is more likely to be problem-solving, but it can be time-consuming and there can be difficulties if there is no access to policy makers with the power to implement certain levels of change.

Whether you adopt a 'top-down' or 'bottom-up' approach initially is likely to depend on your position in your own organisation, the 'house style' of the way your organisation operates, and your influence with other organisations.

➢ In CROYDON the project was able to adopt a combination of the two approaches. Agreement to the existence of the project and commitment to release staff for training or development sessions was initially obtained from senior management in health and social services. This 'top-down' approach was then complemented by an extensive consultation process with people in the field, focussing initially on carers and the voluntary sector and culminating in a borough wide 'consultation day' for practitioners from the three main sectors.

If you are starting 'from the top' it may be possible to follow a similar model, passing control for the project to a working party at field level while maintaining management support.

If you are starting 'from the bottom', you may have no problems generating support for the project among people at your level but face difficulties in processing it through the organisational mazes of the different services. Your first consultation phase may take you longer, or it may be more effective to adopt a less ambitious, more incremental approach. Instead of attempting a borough or area wide project it may be more useful to start with something quite small and local, for example a workshop on the experience of caring based in your own agency, or a seminar on collaboration with other workers who you have direct contact with. The practice development materials of this pack are modular and can be used in a variety of settings like this. An incremental approach allows you to test something out and then build on it if successful.

In adopting a strategy both now and later in the project you may find it helpful to consider the following questions:

- What is your preferred style of working to bring about change?
- What are your powers and responsibilities within your own organisation? Who do you have access to or influence over both inside and outside your organisation?
- What credibility and influence do you have with other organisations?
- What time do you have available for this project?
- How essential/desirable is it that people involved in the project should 'own' it?

3 Assess support

Before formally consulting people it may be helpful to assemble the information you currently have about who and what might support a project. One way of doing this is to use force-field analysis, as described below. This exercise can be repeated at various points during the assessment and consultation phases of the project to take account of changing information and circumstances.

First brainstorm two lists under the headings at the top of the chart:

Factors that might support the project (driving forces)	**Factors that might hinder the project** (restraining forces)

Actions that might activate support and lessen opposition

Check that your brainstorm covers the following areas:

- organisational factors – for instance, the existence and use of joint committees, the number of different authorities involved in the area
- current initiatives in work with carers
- current initiatives in multi-disciplinary work
- organisations likely to be interested or opposed
- people likely to lend support or opposition
- existing policies, management styles and political environment
- existing resources and staffing levels.

You may find that you do not have access to all this information. This is not important at this stage as you are undertaking a preliminary assessment aimed at identifying such gaps as well as focusing your own ideas and helping you to decide who to consult and how to proceed.

The theory of force-field analysis suggests that change can happen either by decreasing the restraining forces or by increasing the driving forces. It is usually more effective to decrease the restraining forces than to increase the driving forces. Decreasing a restraining force is likely to release energy and free movement for change. Increasing a driving force may increase resistance or confrontation or bring further restraining forces into play.

Keeping this in mind, at the bottom of the chart list actions that might activate support and lessen opposition. Your ideas should indicate:

- directions / aims / content areas / strategies for the project
- people it will be important to consult
- arguments it will be important to make.

4 Consult key people

The aim of your initial consultations should be to decide:

- Is there potential interest and support for a project?
- What broad aims and issues should a project address?
- What kind of strategy is likely to be most feasible and effective? Top-down or bottom-up? A major project or an incremental approach?

At this stage it is probably not worth consulting very widely – restrict yourself to a few people selected across agencies and organisations who:

- are likely to provide essential support or information
- need to be involved if a project is to go ahead.

If you do not have direct access to such people, this consultation phase may take longer as you will need to go via third parties or pass the project to someone better placed to carry it forward.

If possible, also consult carers themselves at this early stage (wider consultation in the field is dealt with on pages 13–14).

➢ In CROYDON the preliminary consultation was carried out at senior management level. It led to an agreement in principle for the project to go ahead and the establishment of the Senior Management Advisory Group and a Working Party (see page 8).

At this stage of consultation, as later on, the project is likely to encounter challenges as well as support, especially to do with time and resources and multi-disciplinary work.

➢ These two areas caused particular concern in CROYDON:

Time and resources People at senior management level had serious reservations about what the project might require of their agencies both in terms of staff time away from the job and in future commitment of resources they did not have.

Multi-disciplinary work Studies of primary care and community care have described widespread interprofessional rivalries and defences in multidisciplinary work. Similar problems inevitably surfaced in Croydon. As one senior professional worker said of multi-disciplinary work: ‘I hate the phrase. It makes everybody groan.’ Another made an illuminating connection between this issue and that of carers’ interactions with professionals: ‘Collaboration requires blurring of boundaries (between professions) ... yet boundaries are there to contain and regulate risk ... and there is the danger that once we start listening to carers, so much anger will come out, it’ll be vicious, and we won’t be able to cope.’

It may be helpful in consultation to distinguish between expressions of frustration by overworked and unsupported individuals and informed criticisms of resources available and their use. Acknowledgement and support for individual or group frustration is likely to enhance the capacity to address the problem of resources creatively and in realistic terms.

Objections to the idea of multi-disciplinary work also clearly need to be discussed since dealing with the difficulties of collaborative work in a structured and creative way is one of the aims of the project.

Acknowledging and facing such dilemmas can be liberating. Paradoxically it can increase enthusiasm for a project as well as warning of the difficulties. In Croydon, where the project clearly touched on existing priorities and concerns or dovetailed with existing policies, support was enthusiastic.

5 Review progress

At the end of this first consultation you need to review your progress and to decide whether and in what way to go ahead. The first step is to decide whether you are going for a major project with a full assessment and consultation phase or whether a small scale incremental approach is more likely to succeed.

➢ The CROYDON project was a major undertaking which consisted of:

- a series of ‘practice development’ sessions involving a wide range of workers, representatives of voluntary organisations and carers, discussing ways of improving collaborative work in support of carers
- two ‘policy forums’ which brought together large numbers of people across agencies and included all levels of the workforce from fieldworkers to senior management, as well as

consumer interests. These day long events aimed to formulate agency wide policies in support of carers.

A small scale project might concentrate on running a limited series of practice development sessions in one locality and then review the possibilities for further work. In this case the programme itself acts as a form of consultation and assessment and is used as a means of finding out more about what might be needed and what might be acceptable.

Use the flowchart opposite to decide which type of project you will choose. If you cannot answer the questions in the flowchart you may need to consult with more people and then return to them.

---

6 Establish structures and timescale

The structures and timescale you establish will depend on the nature of your project and on local circumstances. One level of organisation may be enough, or it may be helpful to split the work between two groups with different functions.

➢ In CROYDON, two groups at different levels were set up to direct, advise and monitor the project. These were the Senior Management Advisory Group and a Working Party.

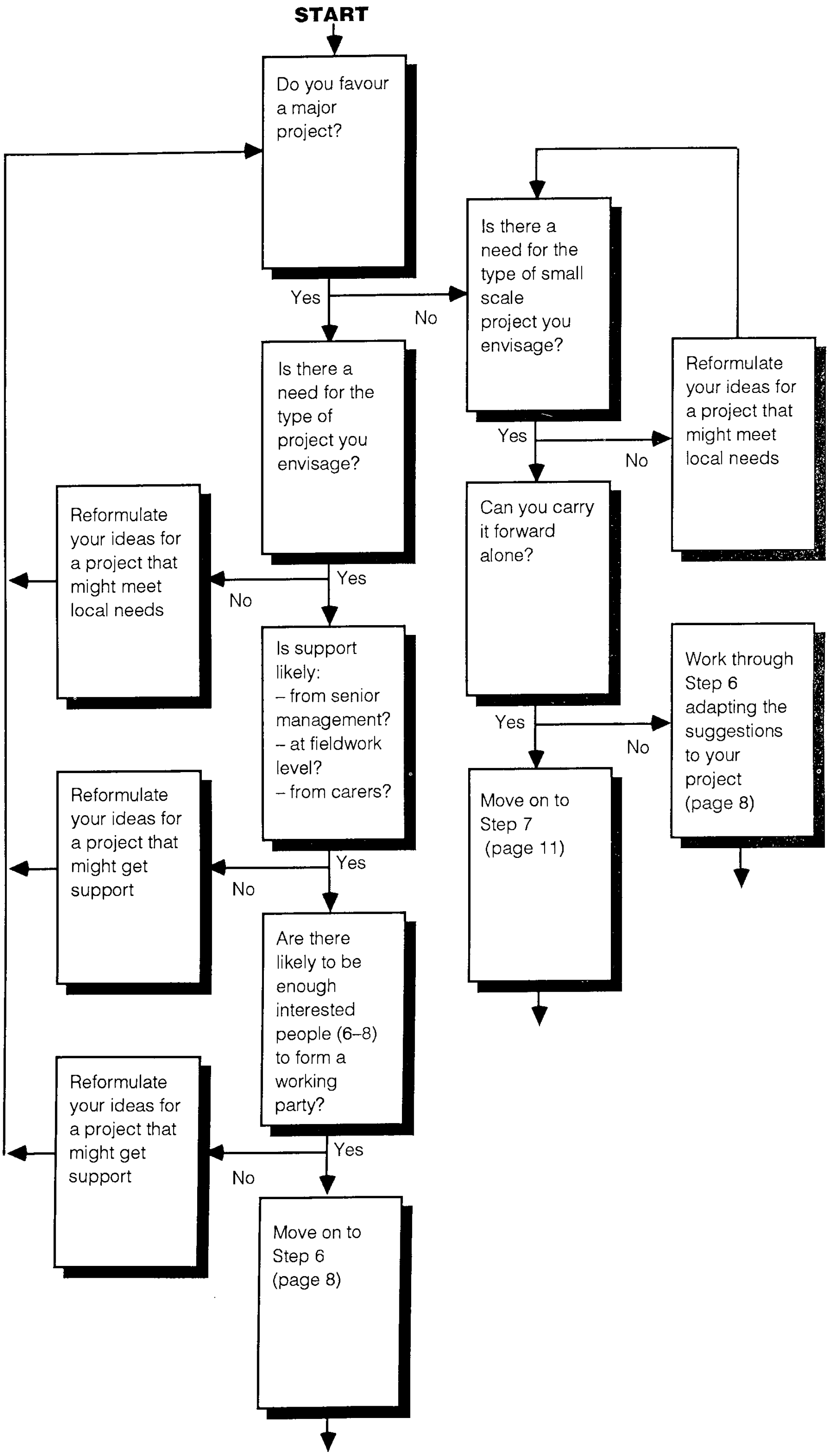
The functions of the Senior Management Advisory Group were to consider the feasibility and resource implications of mounting the project in Croydon and to ensure management support in the implementation of the programme. Members performed an essential role in giving guidance about the type of practice development sessions they felt would be feasible, in agreeing to the release of staff for the practice development sessions and in taking forward the implications of the practice and policy development work. The group met six times in the course of the year and reported to the Joint Consultative Committee. It consisted of:

• District General Manager • Consultant Geriatrician, Unit General Manager • Assistant Unit General Manager (Mental Handicap) • District Training Officer • Representative from the Local Medical Committee	Health Service
• Joint Planning Officer	Joint Appointee
• Director • Assistant Director (Fieldwork) • Assistant Director (Adult Services) • Head of Community and Voluntary Services • Principal Training Officer	Social Services
• General Secretary of the Guild of Voluntary Organisations [CVS] • Representative from the Community Relations Council	

The functions of the Working Party were to identify areas of concern for the practice development sessions, identify target personnel and advise on the content of the practice development sessions. This group also met six times in the course of the year. It consisted of:

• Consultant Geriatrician • Neighbourhood Nurse Manager • General Practitioner • Consultant Psychiatrist	Health Service
• Groupwork Officer • Head of Community and Voluntary Services • Adult Placement Officer	Social Services
• Coordinator from Crossroads scheme • General Secretary of Guild of Voluntary Organisations [CVS]	Voluntary Sector

In Croydon, the Working Party played a relatively minor role, as most of the practical consultation, planning and administration was carried out by the specially employed Project Officer. However, the Working Party members were an invaluable sounding board for ideas and were also important in 'opening doors' for the project. In other locations all this work would need to be taken on by members of the Working Party. This should not be too time


START
Do you favour a major project?
Yes
No
Is there a need for the type of project you envisage?
Yes
No
Reformulate your ideas for a project that might meet local needs
Is support likely:
– from senior management?
– at fieldwork level?
– from carers?
Yes
No
Reformulate your ideas for a project that might get support
Are there likely to be enough interested people (6–8) to form a working party?
Yes
No
Reformulate your ideas for a project that might get support
Move on to Step 6 (page 8)
Is there a need for the type of small scale project you envisage?
Yes
No
Reformulate your ideas for a project that might meet local needs
Can you carry it forward alone?
Yes
No
Move on to Step 7 (page 11)
Work through Step 6 adapting the suggestions to your project (page 8)

consuming if the consultation and administrative work is divided equally between members, and the 14 learning Modules are used as the basis for practice development sessions.

In setting up structures for your project you may find it helpful to check through the following issues:

1 Membership and function Membership criteria for a senior management advisory group and a working party will vary according to the direction your project takes. In both cases you will need to consider:

Key purposes – to provide support, training expertise, practical help, representation of particular interests, and so on.
Representation – achieving a balance between agencies and interested parties and levels of influence.
The political dimension – the need to take account of existing inter-agency relationships of power, rivalry or influence.
Enthusiasm and commitment to the idea of the project.
'Resisters' – it may be valuable to include a resister who will alert you through their opposition to the difficulties a project will face.
Skills and time available for project development and evaluation.
Group size – the need to restrict each group to a workable size for its function.
Involvement of carers, including those from black and ethnic groups, directly or indirectly.

It is likely that there will be tensions between some of these things, for example between the need for all 'political' interests to be represented and the need for a small, tight working group.

A working party clearly needs to be kept small (6–10 members) if it is to function effectively. The advisory function of a senior management group means that it can probably cope with being larger. It may be possible to concentrate 'political' representation in the advisory group and enthusiasm, access, commitment and skill in the working party. Some overlap of membership will be desirable.

➢ In CROYDON some of the issues about group membership were made easier by the fact that health and social service boundaries are co-terminous. In areas where this is not so and a far greater number of agencies overlap, selection of members may be more difficult.

Two of the priorities of the Croydon project were to consult and involve carers and to pay particular attention to the needs of carers from black and ethnic groups. If your project shares these priorities you will need to ensure that working party members represent or have good access to these groups. In Croydon there was initially no representative of a carers' organisation on the Senior Management Advisory Group and only one on the Working Party. Stronger representation of carers' organisations would have been advantageous. Achieving such representation can be difficult and time needs to be given to it.

The Croydon project employed a part time evaluator who gave regular feedback to the project team, Working Party and Senior Management Advisory Group, as well as preparing a final report. It is probably not feasible or necessary in most places to undertake evaluation on this scale although some regular self-evaluation work will be helpful, particularly if practice development is to be tried out in one or two pilot localities. Including someone with experience of evaluation on the working party would therefore be useful.

2 Timescale and frequency of meetings It is important that a project is seen from the outset to have structure, achievable targets and outcomes so that people know what they are committing themselves to. One of the lessons of the Croydon project was that, essential though the consultation phase was, it needed to be seen to have a defined end and a clear practical outcome. Without this there was the danger that people felt their time was being endlessly taken in discussion with no concrete result.

The precise timescale for any project will depend on the extent of its aims, the strategy adopted and the time and resources available to those working on it. A project similar to that in Croydon would need:

Consultation phase	–	3–4 months
Practice development	–	3–4 months
Policy development	–	3–4 months

To achieve this, a senior management advisory group taking on a purely advisory role might need to meet once during each phase. A working party might meet monthly with some responsibilities delegated to individuals.

7 Construct an agenda for change

Both a working party developing a major project and an individual or a pair of colleagues working on a small scale project will need to consider:

- broad aims and ideas for a project
- underlying values and assumptions
- current knowledge of local needs and issues.

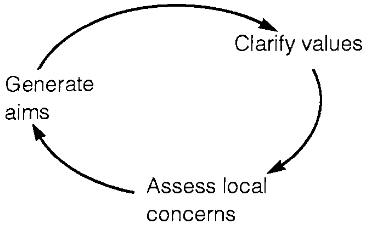
In addition a working party would need to consider its plans for consultation in the field.

A senior management advisory group would need to consider the first three issues plus that of commitment of staff time to the project.

Thinking about aims, values and underlying assumptions

At this stage in a major project it would be unwise to foreclose on aims and programme as these must depend on an assessment of local needs and consultation with local people. Nonetheless it will be helpful to generate ideas about aims and to have thought through any dilemmas surrounding them, to assess how far these aims meet the local concerns already known about and to clarify the values and assumptions informing them. On a small project it is equally important to take account of underlying values and assumptions.

Thinking about aims, values and concerns is often a spiralling process where consideration of one leads to reconsideration of another.



On your own, or at a working party meeting, whichever is most appropriate:

1 brainstorm ideas for aims and issues you think your project should address
2 compare this list with the issues you generated in Step 1 and discovered through consultation in Step 4
3 compare your list with the one below which is derived from the Croydon project.

The project could aim to:

a) raise management awareness of the need for inter-agency planning and provision of services
b) develop policy in support of carers across health, social services and voluntary sector boundaries
c) identify needs for additional resources to support carers
d) promote organisational changes that will make multi-disciplinary work easier
e) promote collaborative ways of working in local areas
f) run training programmes on the needs of carers
g) change attitudes towards carers amongst practitioners
h) develop the skills and knowledge in practitioners to respond more effectively to carers
i) Promote the sharing of information.
j) develop more effective communication between workers from different agencies
k) develop a greater understanding of different agencies and practitioners' different roles and functions in relation to carers
l) pay special attention to the needs of carers from black and ethnic groups
m) involve carers in the planning and development of the programme.

4 discuss the values and assumptions implicit in your list of aims. Think about:

- What value do these aims place on carers?
- What ideas about the carer's role and responsibilities are implicit in these aims?
- What expectations are being made of carers in these aims?
- What assumptions are being made about the role and practice of different agencies?
- Are these values and assumptions ones which are appropriate to the project?

➢ Three issues that emerged strongly in CROYDON during discussions of the possible aims of a project were:

- Is it training or development work that is required? Training here was seen as addressing the skill and knowledge of individual workers, while development might be professional development considering such things as personal stress and coping strategies or service development looking at the systems, agencies and inter-relationships they were part of.

- What about the resource implications of opening up this area? People at grass roots level were concerned that the project should be willing to: 'talk about finding further resources if that's what the project discovers is needed.' Others (at management level) had serious reservations about: 'commitment of staff time to a panoply of activities when their case loads are expanding, they are already overstretched ... they don't need time to reflect on resources, they need time to do the job.'

- What is the ultimate aim of support for carers? Should it be (as one carer expressed it) to 'pat me on the back and encourage me to carry on'? Should it be to provide material resources and practical help to enable them to keep going? Should it be to help them find a way to relinquish care when necessity dictates?

The first issue was clearly resolved in the decision to adopt a development rather than a training model. The resource issue led to a more modest programme being adopted than had originally been envisaged and was a continual source of tension and uncertainty in both practice development and policy discussions. Given the current scarcity of resources this is likely to be true of any similar project. The final issue highlighted the need to consider the underlying values of the project.

By the end of this stage, the working party on a major project should be better prepared to undertake the detailed assessment and consultation phase described below. The individual organising a small scale project should be able to move on to Step 10 and select from the aims generated those that will be most appropriate for the project.

8 Assess the situation

In order to develop a programme that is relevant to local needs, the working party will need to assemble as much information as possible about the existence of carers, existing awareness of them and support for them, and existing collaborative or multi-disciplinary work. Some of this information will probably be known to working party members, some can be obtained through the consultation process. Gaps may need to be filled by guesswork or by extrapolation from studies done elsewhere. Five key questions that need to be answered are:

(1) Who are the carers? How many of them are there? Who do they care for? What problems do they experience? What is their class/ethnic/gender/geographic profile?

➢ If CROYDON is typical, the answer to such questions is likely to be a resounding 'We don't know'. This points to the need for the project at some stage to address how agencies can collaborate to increase the scant information they may already have about carers. One estimate in Croydon was 20,000 carers out of a total population of approximately 320,000. It was generally agreed that greater precision in the social arithmetic of care in the community was urgently needed.

(2) What work is already being done with carers? Are there any projects already in existence? Are there any organisations, departments or individuals with specific responsibilities for carers? Are there organisations for particular client groups who also work with carers (for example, National Schizophrenia Fellowship, Mencap, Mind, Age Concern)?

➢ In CROYDON the consultation day (see below) showed that a great deal of work was already being undertaken but that people often work in isolation, and that what is done is unrecognised and often unused by colleagues in different sectors. The need for better information networks and possibly a central, regularly updated resource bank emerged clearly.

(3) How good is existing support for carers? What is the general awareness of carers' needs in different agencies? Do they have a high or a low profile? Would practice development sessions be starting from scratch or on the basis of existing awareness?

(4) What multi-disciplinary forums currently exist? What is the state of current collaboration between health and social services? What forums exist and at what levels? What powers and funding do they have and what use is made of them? How good are relationships with the voluntary sector?

(5) What are the structures of power and authority? What pressures are likely to produce acceptance or refusal of the project?

➢ The CROYDON project found that responsibilities were frequently obscure and confused and certainly variable from one care group to another and from one neighbourhood to another in ways that often appeared ad hoc and unsystematic. This confusion also produced difficulties in the consultation process in that it was difficult to know if the right channels had been gone through and the relevant people invited.

The information that is obtained in this way can be fed into the force-field analysis begun earlier.

9 Consult in the field

One of the first tasks of a working party must be to plan the consultation phase. The aims of consultation in the field should be to:

- promote support for the project
- gather information about existing work with carers
- develop a programme that will meet local needs
- ensure management commitment across agencies.

Experience in Croydon suggests that a definite timescale and limits for this task are essential. Check that you have agreed:

- who you wish to talk to
- what you want to discuss
- a date for these meetings to be completed by
- how you are going to report the information.

The consultation process in Croydon

➢ In CROYDON consultation took the form of individual meetings and a borough wide 'consultation day' which 80 people attended. Experience in Croydon suggests that in addition to representatives from health, social services and the voluntary sector, there are three groups it is particularly important to contact at this stage: carers, people from black and ethnic groups, and GPs.

Carers The Croydon project was criticised for relying on carers' organisations to represent carers' views rather than involving individual carers in the consultation day. It was felt that carers often hold important information and that their views concerning ways in which each agency can best respond to their needs must be fed into any plans for training or development work.

People from black and ethnic groups Considerable effort was made in Croydon to contact representatives from black and ethnic groups, to ensure that the project was relevant to a wide population. It was thought that 'culturally specific' schemes for carers might be needed. In practice it wasn't easy to find people with special knowledge of the needs of carers in black and ethnic groups. Some black and ethnic carers who were represented disagreed with the view that culturally specific schemes were needed. More time and effort was clearly needed to establish the views and needs of this much under-represented group.

GPs GPs play a vital role in providing access to services and supporting carers. In Croydon, as is likely elsewhere, it took time and effort to secure their involvement and cooperation.

GPs tend to be reluctant to take time off from their surgeries and other work with patients and may be difficult to contact. The best way of approaching them is through the local medical committee or through the local postgraduate medical centre.

The Croydon Project Officer found it easier to make contact with people from voluntary organisations than with those from statutory organisations. The consultation day was in part an attempt to overcome this. If the consultation work is undertaken by a working party that is already fairly representative then contacts overall may be easier and quicker to make and a consultation day may not be necessary. It must be said however that the Croydon consultation day was an enormous success. It was itself an example of multidisciplinary collaboration, provided publicity and raised awareness of carers as well as contributing to the development of the programme.

➢ The main outcomes of the consultation process in CROYDON were to:

- identify the level of support for the project (mixed, with stronger support from the voluntary sector and considerable reservations from parts of senior management in social services)
- identify existing work with carers and awareness of carers needs (more than had been imagined but extremely fragmented)
- establish what kind of programme might meet local needs (development rather than training was asked for)
- prepare the ground for the development of the main project.

Pressures and dilemmas

The consultation process in CROYDON highlighted a number of pressures on the project that are likely to be replicated elsewhere.

➢ **Resources** The problems of resources have already been mentioned. Resistance to the project on these grounds was felt particularly strongly by people in managerial roles who had to decide whether or not to release hard pressed staff from urgent tasks in order to attend training or development sessions. People in voluntary organisations were angry that money could be made available for training but not for practical help to carers.

The rhetoric of support Connected to this was the suspicion voiced by carers or their representatives of the rhetoric of 'support for carers' policies. As one person at the consultation day put it: 'My fear is that this will become a circular event. A lot of it is merely rhetoric. The people who will gain least are the carers themselves, mostly it will be the professionals.'

'Not just another training day' In Croydon those who were most enthusiastic for the project were also insistent that training in itself would not be adequate, that the project must lead to changes in practice in policy and in resource allocation.

Mistrust and suspicion As discussed earlier multi-disciplinary work itself may be feared and objected to. In addition the Croydon project found some mistrust of senior management and the upper reaches of planning and policy making among carers, people from voluntary organisations and even many field workers employed by statutory organisations. Collaboration between statutory and voluntary bodies was also an area of suspicion. On the one hand representatives from voluntary organisations expressed, as one put it: 'anger about statutory jobs being sent to the voluntary sector.' On the other hand some professionals in statutory agencies had doubts about the wisdom of involving voluntary organisations in support for carers.

10 Finalise aims

Final aims and objectives for the programme must be agreed on the basis of the assessment and consultation work, taking into account appropriate values, local concerns and issues, the time and resources available and the likely support and interest. Depending on the model you have chosen, you may be doing this alone or at a working party meeting. Once again it may be helpful to use force-field analysis to assess the degree of support you now think the project has, focusing on each individual aim. Force-field analysis can be used both to decide whether or not to pursue a particular aim and to develop objectives and strategies for its pursuit.

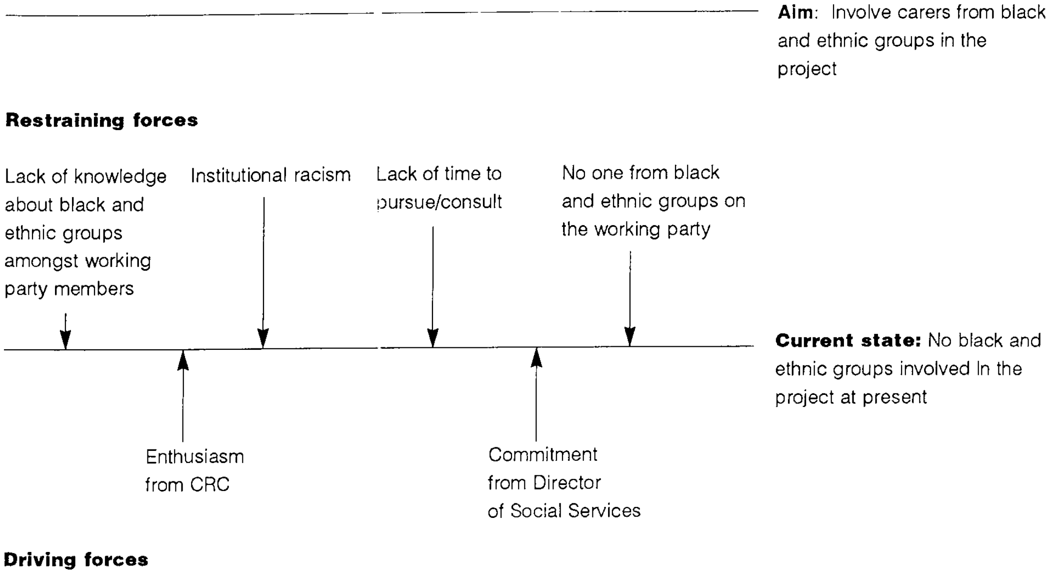
Return to the brainstorm of aims you completed in Step 7. Take each one in turn and draw up a force-field for it as in the two fictitious examples below.

1 At the top write the aim.
2 In the middle write the corresponding current state that you are trying to change.
3 Brainstorm the restraining and driving forces and enter them on either side of the line.

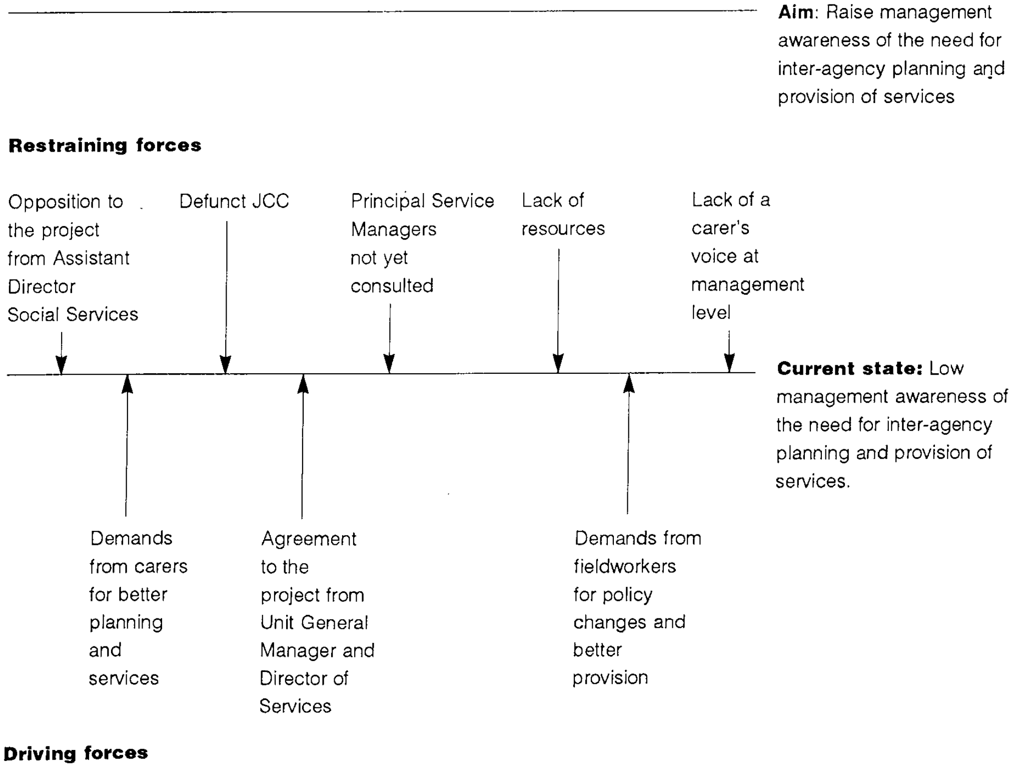
If you are doing this at a working party meeting, it may be helpful to divide into pairs, each pair taking a few aims and drawing up a force-field analysis for each one on large sheets of paper which can then be pinned to the wall. The group can then look at each analysis and decide:

- should this aim be included in the programme?
- what actions will be needed to achieve this aim?

Example 1



Example 2



In the first example of the involvement of carers from black and ethnic groups, the restraining forces are clearly strong, reflecting the current social and political distribution of power. With a less important aim, such strong restraining forces might be a case for dropping it from the programme. In this case however there is an underlying value at stake and the strong restraining forces show the importance of giving special time, planning and consideration to the aim.

In the second example the forces are more evenly balanced but point to specific needs if the aim is to be achieved. In this case it is important to be clear that it is beyond the project's scope to act on some of the restraining forces (the defunct JCC and the lack of resources). The other three restraining forces could be weakened by further consultation and involvement and the whole aim might be helped by the kind of policy forum used in Croydon which could bring together those making the demands and those with the power to meet the demands.

Moving on

Having defined the aims of your project, you should now be in a position to move on to plan your programme in detail. This is covered in the next few pages.

Developing the programme

This Section deals with putting your aims into practice. There are four main areas to consider:

1 The overall *programme outline* – the different elements and how they will relate to each other.

2 The detailed choices you will need to make in setting up *practice development sessions.*

3 The detailed plans you will need to make for *policy development forums.*

4 The *evaluation* activities you are able to undertake, and how these will be 'put in place' within the project.

Each of these is considered in turn. The Croydon project provides useful illustration, but not necessarily a model to follow – each local project must determine what is most appropriate under its circumstances. On a small project you will obviously have less development work to do, but it is still worth checking your plans against the points outlined below.

1 Agreeing an outline programme

In developing an outline programme, the individual(s) or planning group responsible will need to think about:

- ☐ What kinds of groups / forums / workshops would be appropriate?
- ☐ Are there existing forums / study groups / seminars that could be used?
- ☐ Which objectives will each forum try to meet?
- ☐ Where should each forum be based? Which ones should be locality based and which borough / area wide?

Having developed a draft programme, you will then need to check:

- ☐ Does your programme accurately reflect your consultation phase?
- ☐ Does your programme meet the aims and objectives you set?
- ☐ Have you tested agreement with people in the field?
- ☐ Have you tested agreement with senior management?

➢ The consultation phase in CROYDON resulted in a proposal for:

a) Two 'practice development' groups focusing on the improvement of inter-professional relationships in the support of carers. Meeting for five two-hourly sessions, membership of the groups would include the range of professionals in specific neighbourhoods likely to be concerned with carers (eg GP, social worker, district nurse, community psychiatric nurse, home help organiser, consultant, ward sister) and members of voluntary and carers' organisations. The aim of the groups would be to draw out principles of good collaborative practice and identify issues relating to service and policy developments which would benefit from discussion in other parts of the programme.

b) Two area level service development workshops focusing on issues such as appropriate forms of assessment and intervention, inter-organisational networking, the provision of emotional and practical support, resources needed, implications for authority wide policy formulation. These would be four half day workshops at monthly intervals based in two areas. Membership would be invited from all levels of staff of statutory agencies and members of voluntary and carers' organisations.

c) Two borough wide policy development forums. These would address issues raised in the other two groups and formulate and evaluate a range of policy development options. Members and senior managers of statutory agencies and representatives of voluntary and carers' organisations would take part.

d) The Working Party would be expanded to include representatives of carers' organisations and shift its role to facilitate long term multi-disciplinary training in support of carers.

e) The Senior Management Advisory Group would be expanded to include representatives of carers' organisations.

The design of the programme was intended to:

- address real policy and practice issues
- draw links between the consideration and resolution of issues at policy and practice levels
- focus on the processes of inter-agency planning and multi-disciplinary practice
- link directly with managerial decision making about policies and allocation of resources
- embody equal opportunities dimensions
- involve carers at all stages and in all forums
- provide the opportunity for developing practice skills and approaches to service delivery.

Although the proposal was well received, particularly by people in voluntary organisations, some people in the Senior Management Advisory Group had reservations about its extensiveness and the time involved. This resulted in the abandonment of the plans for area level service development workshops and the restriction of the practice development groups to five one and a half hour lunchtime sessions. The Working Party did not extend its role and the Senior Management Advisory Group did not take on representatives of carers' organisations. The Croydon experience points to the need to be sensitive to time pressures, and to the differing demands and needs of people in the field and people in senior management.

2 Organising practice development sessions

The Croydon project was praised by people on the ground for its careful preparation and for not 'parachuting' in. This spirit of sensitive consultation needs to be carried on in the organisation of practice development sessions. The programme needs to be explained and individual needs assessed and catered for as far as possible. There are five main tasks:

- selecting areas
- selecting participants
- selecting facilitators
- selecting appropriate materials
- making practical arrangements.

The main requirements in each case are discussed below, in relation to the Croydon experience.

Selecting areas

➢ In CROYDON two contrasting areas were chosen, one in the more prosperous South and one in the North East which has a large black and ethnic population. The North East is characterised by relatively undeveloped inter-agency and multi-disciplinary collaboration while the South enjoys good working relationships between professions and agencies. It was hoped that by focusing on contrasting areas valuable information about the factors affecting multi-disciplinary work and shared learning could be gained.

In other areas the criteria for choice may be different. It may be more appropriate to focus on localities where support and interest is high for example, particularly if there is little time for extended preparation. Other factors such as the needs of the local community, current awareness of carers, or the current pressures on people in the field may also be important to consider.

Selecting participants

➢ In CROYDON the North Eastern practice development group consisted of a community development officer attached to social services, a home care organiser, a social worker, a social work team leader, a rehabilitation officer, a community psychiatric nurse, a health visitor, a GP, a district nurse, a physiotherapist, a neighbourhood nurse manager, the liaison nurse from the elderly care unit, a worker from Crossroads, a carer, a representative from an Afro-Caribbean lunch club for the elderly and a representative from a community centre. The Southern practice development group had a similar membership.

In retrospect it was felt that representatives from the DHSS and housing departments should also have been invited, as these organisations are often central to carers' needs.

Some participants were approached direct and some through their managers, who then sent or volunteered them. The Project Officer felt that individual contact was helpful in explaining the nature of the programme and also in forming an idea of participants' needs. It was important to check out with people how much they actually worked with carers and what the term 'carer' actually meant to them. It was also important to explain the nature of the practice development groups – that they were intended to be working forums and that regular commitment was important to their success. Some participants wanted a more flexible, 'I'll come if I can' arrangement. Others wanted to be able to bring students or colleagues to the occasional session to see what was going on.

As in the rest of the project achieving the involvement of carers, black and ethnic groups and GPs needed particular attention. This resulted in one GP in each group both of whom were regular and interested attenders. Black and ethnic groups were under-represented throughout and so greater effort was made to involve them in the policy development forums by organising a special meeting to promote awareness and involvement.

The involvement of carers was more problematic. There are strong arguments for their inclusion, such as allowing their voice to be heard and encouraging workers to consider them as part of the team providing care. However their inclusion in the Croydon practice development groups raised a number of difficulties:

- Workers involved with the carer felt inhibited in open discussion.
- Carers often felt unable to contribute to discussions about organisation of services and policy making and wondered why they'd been invited.
- It was difficult for a carer who needed a lot of help and support to generalise from personal experience.
- Carers wanted to state what they needed and receive a service rather than be involved in its organisation.
- It was difficult to deal with a carer's anger and bitterness in the format of a discussion group.

The Project Officer in Croydon was working 'from the outside' and tended to follow up leads from one person to the next about who should be invited. In other areas, an 'inside' individual or working party with responsibility for planning the practice development groups might be better placed to suggest likely participants and to select people who are, or should be, working together.

In selecting participants it is important to discuss and negotiate issues such as:

Commitment The desire for flexible attendance is understandable, but is likely to detract from intensive work if only a short period is available.

Existing professional relationships It may be best not to include people with immediate responsibility for others in the group, nor people who are known to have fears or be antagonistic about working together.

The involvement of 'hard to draw in groups' such as carers, black and ethnic groups, and GPs. This has already been discussed in terms of setting up the project (see page 13). In terms of practice development, involving people from such groups is likely to take extra time and may require special channels. For example, for an all day workshop involving GPs it would be advisable to send the programme to the administrator of the local Post-Graduate Medical Centre, requesting 'Section 63' approval.

The involvement of carers in practice development groups has both pros and cons. In Croydon, their involvement was problematic, and it may be that other ways of ensuring their involvement in the whole programme needs to be considered. If you do wish to involve carers, bear in mind that:

- ex-carers or carers who are part of organisations such as the current (1987) Association of Carers and the National Council for Carers and their Elderly Dependants may be better placed to generalise from their experience and contribute to discussions about organisation of services
- carers who are relatively confident and articulate are less likely to be overwhelmed by a group of workers
- it will be easier for carers if they are not involved as clients with any of the workers in the group.

Selecting facilitators

➢ In CROYDON the Project Officer acted as facilitator for the sessions. In other areas facilitators may be drawn from the working party, staff of agencies involved, their training departments or from outside bodies.

The main requirements are basic facilitative skills, as content for the sessions is provided in the materials. Sessions could also be jointly run. There is more detail on this in the 'Group facilitator's guide' to the learning materials.

Selecting materials

Materials need to be selected on the basis of the programme's aims and objectives and participants' needs. This is discussed further in the 'Group facilitator's guide' to the learning materials.

Making practical arrangements

As with any training event there are the usual requirements for a comfortable, accessible venue. If carers are to be involved, arrangements for respite care or a sitting service will also have to be made.

➢ In CROYDON the groups took place at lunch time and lunch was provided. This may have been a positive factor in overcoming the time problems but it also lessened the actual time available for discussion and may have lessened concentration.

When you review your plans for practice development sessions, check that:

☐ localities are selected according to relevant criteria
☐ local needs are taken account of
☐ local managers are consulted and their agreement sought
☐ participants are people who do or should work together
☐ participants are happy about the nature of the sessions planned
☐ participants can make the necessary commitment
☐ sufficient attention has been paid to the issues in involving carers, black and ethnic groups, and GPs
☐ the person chosen to facilitate each group has all the necessary skills
☐ the materials selected are likely to meet participants' needs
☐ the venue is comfortable and accessible
☐ the timing is appropriate for participants
☐ all the necessary practical arrangements have been made for refreshments, respite care, etc.

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3 Organising policy development forums

➢ The two CROYDON policy development forums were all day borough wide events, each involving about 80 people. They were intended to address issues arising from the practice development groups which were beyond the scope of their resolution.

In planning your own policy forums, you will need to consider:

☐ What objectives should the forums try to meet?
☐ What is the relationship of the forums to the work done in practice development groups, in particular the work on Action Plans?
☐ What kind of forums will be appropriate – at what level should they work?
☐ Who should be invited?
☐ What content will be appropriate for workshop sessions?
☐ What speakers or presentations will be appropriate?
☐ How can attendance by carers and representatives of carers and black and ethnic groups be ensured?
☐ What is the most appropriate way to involve carers in the workshop sessions?

Outline of the Croydon forums

➢ *The first policy forum* consisted of:

i) Presentations on carers' needs by the London Development Officer of the National Council for Carers and their Elderly Dependants, and the local chairperson of the Association of Carers.

ii) Presentations by the practice development groups of guidelines and proposals for better collaborative working.

iii) Small groups discussing:

- working with carers of people with mental illness
- working with carers of people with mental handicap
- working with carers of people with physical handicap
- working with carers of older people
- working with black and ethnic carers
- working with carers who are on their own and isolated.

iv) Small groups discussing:

- respite care
- information
- participation
- training
- key worker schemes
- locating the carers.

v) Plenary.

The first and second forums were separated by a period of a month. Small groups met inbetween to take forward the ideas under (iv) above. *The second policy forum* consisted of:

i) Presentation of refined guidelines on collaborative working, and reports from the small groups.

ii) Continued work in small groups on the policy implications and challenges in each of these areas.

iii) A panel discussion of future options with the Chairperson of the Association of Carers, the Unit General Manager (Community) of the Health Authority, the General Secretary of the Guild of Voluntary Organisations, and the Director of Social Services.

The gradual build up of consultation in the project as a whole meant that a wide selection of people involved with carers and carers themselves were invited to the policy forums. Carers' participation was more successful here than in the practice development groups but the issue of providing alternative cover remained difficult in some cases and needed better attention. GPs were not well represented, perhaps reflecting the fact that this time the Project Officer had paid most attention to recruiting carers including those from black and ethnic groups. Representatives from such groups were present but black and ethnic carers were again under-represented. A special meeting had been held to try to make contact with the black and ethnic community and although this had been mildly successful it had come too late in the project to feed through effectively to the policy forums. An additional problem that came to light at the forums themselves was that some sectors of middle management had not been sufficiently involved.

Problems and issues in organisation

In preparing for a similar event, it may be helpful to note from the Croydon experience that:

- The fact that the forums were multi-level as well as multi-agency was felt to be particularly helpful

- The main difficulty in the forums was that they weren't felt to be operational enough. Senior management were looking for clear strategies and options and the work of the project had not yet progressed to this. Moreover there was a failure to consult with and involve principal service managers who would be responsible for 'operationalising' the recommendations of the practice development groups. The intermediate level service development workshops which were abandoned due to time pressures (see page 17) might have been helpful in this respect.

4 Evaluation

Evaluation was a major part of the Croydon project. It should be a part of any similar project, whether it is a major undertaking or a small scale or incremental one. Evaluation can be *formative*, feeding back findings into the project as it proceeds, or *summative*, reporting on the project as a whole when completed.

➢ In Croydon the evaluation was intended to be both formative and summative. It covered all stages of the project, including the practice development sessions. The key question to be addressed in the evaluation emerged from the pilot phase of the project. It was *'What processes of shared learning in multi-disciplinary groups are most successful in advancing policy and practice in support for informal carers?'* The detailed questions examined were:

a) Which dilemmas and issues are in fact taken forward as matters for discussion within the various practice and policy development sessions? Why?

b) Which issues do different groups back off, abandon or avoid? Why?

c) How far are issues dealt with, and in what ways? How much ease/ difficulty is experienced in arriving at agreements in different groups? What kinds of group activity are most helpful?

d) What kinds of action plans, contracts, etc emerge from development sessions? What additional work is agreed beyond the sessions themselves? What actions are implemented? What kind of mechanisms exist to implement them?

e) What kinds of practice/policy documentation are drawn upon in the development sessions (eg case histories, service guidelines, operational policies, strategic plans)? How useful are these found to be?

f) What reference is made to the development sessions to wider literature from further afield (such as research reports, theory/policy papers, etc)? How useful is such information found to be?

g) What other kinds of published teaching/ learning resources are referred to or used in these sessions? How useful are such items or packages found to be?

The methods used in evaluation were:

i) participant observation at the practice development groups and policy forums

ii) assembly of profiles of people attending the various events, their background, position and current involvement with carers

iii) recording of practice development and policy forum sessions

iv) follow up interviews with key individuals

v) compilation and analysis of all key documents emerging in Croydon during the project

vi) review of relevant literature.

Small scale initiatives

The Croydon project used a part time independent evaluator to undertake this work. It is unlikely that other projects will be able to evaluate on this scale. The most appropriate activities elsewhere are likely to be:

i) Use of interviews or questionnaires prior to practice development groups to pinpoint current involvement with carers and expectations of the sessions. This can then be used as a baseline from which to measure change. It could be done as part of the initial selection of participants.

ii) Feedback and evaluation from facilitators at practice development groups and policy forums. This can be done in discussion or by questionnaire.

iii) Use of questionnaires to participants at the end of practice development groups and policy forums to evaluate satisfaction/ usefulness/outcomes. (An example is given in the 'Group facilitator's guide' to the learning materials.)

iv) Use of participant observation at key meetings and events.

v) Selected follow up interviews at a later date to evaluate implementation of action plans agreed in practice development groups and policy forums.

vi) Interviews with key figures in senior management as the programme develops to pinpoint reception of the project and satisfaction/ dissatisfaction with its progress.

vii) Review of the relevant literature.

Further details of the evaluation of the Croydon project can be obtained from the King's Fund Informal Caring Support Unit.

The extent of the evaluation done will clearly depend on the time available to people initiating your project, as individuals or as a working party. Experience in Croydon suggests that it is very easy to put aside or postpone discussions about evaluation. People responsible for the project will need to create time in the programme both for the evaluative work to be done and for it to be fed back and used.

As you develop the final details of your programme, ensure that you:

☐ agree on the fundamental question(s) your evaluation should address.
☐ agree the strategy (formative, summative or both) and the methods your evaluation should use
☐ arrange for the necessary questionnaires to be designed and produced.
☐ allocate responsibility for carrying out the evaluation.
☐ build in time for the feedback and discussion of evaluation results.

The final section of this booklet looks at the process of project review, for which evaluation data is crucial.

Reviewing your project

Project outcomes

At the end of your project you will want to check that it has made the impact you intended in producing change for carers. It is likely that you will look for outcomes within your service, group of services, or voluntary group for example, changes of policy, revised structures, shifts in the style of management, new or improved systems of communication and the impact of these on carers.

Individuals too may manifest changes which have taken place as a result of the project. You may want to look for outcomes amongst:

- managers within the organisation(s) involved
- staff of the organisation(s) involved
- members of the local authority/ health authority and officers from voluntary organisations
- participants at the various workshops/ sessions/ activities which have run during your project
- carers and the people for whom they care in the local community.

The outcomes in Croydon

➢ In CROYDON, one formal outcome of the project was an agreed statement as follows:

> *... the Senior Management Advisory group agreed that the four people who comprised the panel at the second Policy Development Forum would take responsibility for orchestrating follow up to the project, and that this would include a report to the Joint Consultative Committee.*

These four were the Chairperson of the Association of Carers for Croydon, the Unit General Manager (Community) in the Health Authority, the General Secretary of the local Guild of Voluntary Organisations [CVS], and the Director of Social Services.

The list of follow up activities which was discussed and recommended at the policy development forum included the following ten items:

- A project to collect and collate existing information of use to carers.
- A continuation of the work of the interest groups on, for example, respite care and training. Responsibility for these would be with the facilitators at the Policy Development Forums.
- A report to the Joint Chief Officers Group and the Joint Consultative Committee about the progress of and follow up to the Croydon project.
- A list of those involved in the project to be circulated, to be available to neighbourhood and area managers for the purpose of promoting local groups of carers and professionals.
- Further discussion of the value of a special project and of a post to coordinate and promote services for carers.
- A commitment on the part of the health authority to review aspects of services, for example those available at night time, and to involve carers in training programmes on an experimental basis.
- A review of currently available services to ensure these are coordinated and focused on priority needs.
- A further commitment by these two services to consider greater user involvement in service planning and provision.
- A promise of increased training for social services staff about the support for carers through programmes on welfare rights and care of elderly and disabled people.
- Consideration to be made to improvements in respite care and greater help with continence advice.

Reviewing the outcomes

The following checklist highlights the sort of differences you may see at the end of your project. It reflects the Croydon experience, but it can be applied and developed to suit other settings and other circumstances. There may well be questions you want to add, based on your discussions of aims and evaluation during the project planning phase.

Participants at the practice development workshops

☐ What differences have been made to personal, individual work?
☐ What differences have been made in collaborative work between participants?
☐ Have there been demands for further workshop sessions?

☐ How far have differences of view about preferred outcomes for carers been clarified?

Colleagues of those who attended the workshops

☐ What influence have the workshops had on colleagues' work and awareness?
☐ Have there been demands for more such workshops, in different locations perhaps, with different personnel?
☐ Have there been demands for more information:
  - about the workshops themselves?
  - about the issues discussed?

Participants at the policy development forums

Carers' organisations:
☐ Have their needs been heard?
☐ Have they achieved any practical change?
Individual carers:
☐ Have they achieved improved services, and better involvement in them?
☐ Have they better access to workers?
☐ Have they better access to emotional and/or practical help?
Field staff:
☐ Have they been heard?
☐ Are they getting the practical changes they want?
☐ Do they feel influential?
☐ Are they setting up projects of their own?
Voluntary organisation staff:
☐ Have they been heard?
☐ Are they getting the practical changes they want?
☐ Do they feel influential?
☐ Are they setting up projects of their own?
Managers:
☐ What action have they taken in:
  - adding new services?
  - expanding existing services?
  - amending existing services?
  - reviewing existing services?
  - providing training?
  - providing information?
  - following up the project?
☐ Have their attitudes changed?

Members of local authorities, (LA, DHA etc), Committee members of voluntary organisations

☐ Have their perspectives changed?
☐ Have they made any commitment to policy change?

The organisations involved

☐ Are there new (or revised) policies, structures, styles of management, systems of communications?
☐ If so, what form do these take: job descriptions / joint committees / working parties / lines of reporting etc.

The review process

Answering the type of questions posed in the above checklist should help you to address the four key issues in project review:

1 Who got what out of the project itself? You should list here all the possible beneficiaries and review the evidence about outcomes from any formal workshops, meetings or other sessions that were conducted as part of the project.

2 Which aims of your project were achieved, and which were not? You should certainly consider why some aims were achieved, but also, particularly, why some aims were *not* achieved? What (or perhaps who) was it that stood in the way of the changes you wanted to see happen? You may find it helpful to use force-field analysis, as discussed earlier in this package (page 14).

3 What unplanned outcomes were there? Again, consider why these happened.

4 What would you repeat/avoid/amend/ add if another project along these lines were to be repeated in this or another form?

The evaluation data that has been gathered by project initiator(s) and group facilitator(s) (see page 22) should help you to formulate views on each of these questions. It is important to have a procedure which allows you to make full and sensible use of the information gathered about the project.

Looking to the future

At the end of the project it is essential that you discuss what actually happened in the appropriate forum. If yours is a major project, you will need to discuss outcomes quite formally, at a meeting of the senior management advisory group for example. Written evaluation data may well be useful.

In a smaller scale project you might simply meet informally with colleagues, to decide if it was all worth it.

Planning the next stages

You may want to consider if there is a need for more development activities:

- policy days
- practice workshops
- training for workers and/or carers
- consultations between services and/or with carers
- information for services and/or carers
- any others which were within your original plan

or which you have subsequently discovered are important.

If you decide to continue the project in some form, then rather like a circular tour, you need to set up a new planning mechanism to develop your plans. You should at this point go back to the start of this booklet, to help you set up the necessary new mechanisms. In so doing, the questions which were raised early on about the scale of the change you want to carry are crucial. You need to decide whether you are interested in incremental, gradual change or a more radical, major change (see page 7).

Action for carers – the nationwide challenge

The project in Croydon is described in some detail in this package because it was the basis for its development.

The model it provides is not necessarily complete, and is offered as an example rather than a blueprint. It illustrates a process rather than presenting a solution.

Nationally, there is increasing recognition that carers make a vital contribution to care in the community. For many years they have been taken for granted, and their severe problems have been hidden from the public view. Throughout the country there is increasing evidence that people want to confront the dilemmas presented by the way in which care in the community is organised and resourced.

The people in Croydon are not alone in demonstrating a willingness to explore new ways of working, or in rethinking their priorities in support for carers. But, like many others, they are trying to find solutions at a time when many agencies and professionals are hard pressed, and when there are competing demands for scarcer resources.

In the future, care will be needed for increasing numbers of very elderly infirm people and for younger people who formerly had less likelihood of living into adulthood. But, as social and economic conditions change, the availability of carers and patterns of caring in the future are surrounded by uncertainties.

What is clear is that care *in* the community can no longer be confused with care *by* the community. In the absence of organised support for those who take on the caring role, community care will be in danger of being viewed by carers and people with disabilities as a withdrawal of help, and indeed as a policy of neglect.

Whatever changes may occur in the way community care services are structured, the issue of collaboration between agencies and professionals will remain. It is inconceivable that any one agency could provide carers with all that they need.

This package offers a particular approach to collaborative working. The complexities and conflicts that are prominent in local districts mean that the route suggested will not be an easy one. But bringing about change for the better is clearly within the grasp of those who are determined to overcome such difficulties in a creative way. The challenge is there.

Resource list

This list does not attempt to be comprehensive. It is limited to ten key references, and focuses on studies that deal with informal care in general. It omits the many excellent but more specialised studies that are available on informal care for groups with particular needs (such as people with mental illness, people with a mental handicap, people with a physical handicap, older people, etc).

Allen, I with Wicks, M, Finch, J and Leat, D (1987) *Informal Care Tomorrow*, Policy Studies Institute
Short booklet (44 pages), comprising the papers from a seminar in 1986, sponsored by the DHSS, on 'The Future Availability of Informal Care'. The focus is on the a nalysis of policy, and it brings together several leading researchers, covering the role of the family, of women, and of the voluntary sector.

Audit Commission (1986) *Making a Reality of Community Care*, HMSO
Reports a major review by the Commission of 'value for money', with particular reference to expenditure through the social security system. It concludes that progress towards care in the community has been slow and uneven, and highlights the numerous policy conflicts that undermine joint action between different agencies at local level.

Bayley, M with Seyd, R and Tennant, A (1985) *Final Report: Neighbourhood Services Project*, Dinnington Paper No 12, Department of Sociological Studies, Sheffield University
This is the last of a series of working papers on a DHSS-sponsored action research project which established a new community-based model of health and welfare services provision in a Yorkshire mining village, concerned to promote cooperation between different statutory services and between these and voluntary provision. Earlier reports in the series provide a wealth of detail on formal and informal support, 'before and after', in different sectors; and on referral processes and joint management procedures.

Briggs, A and Oliver, J (Eds) (1985) *Caring: Experiences of Looking After Disabled Relatives*, Routledge and Kegan Paul
An important collection of testimonies from a range of informal carers. They speak in their own words about their feelings, their practical problems, and the response of the welfare state to their plight.

DHSS (Social Work Services Development Group) (1983/84) *Supporting the Informal Carers*, DHSS
A series of reports that were part of a project mounted by the DHSS during 1983/84, to highlight the needs of carers and their representatives, and to stimulate new initiatives on the part of service-providing agencies. One Report 'Fifty Styles of Caring' summarises 'models of practice for planners and practitioners'; a further seven Reports consist of papers from a series of Regional Seminars around the country.

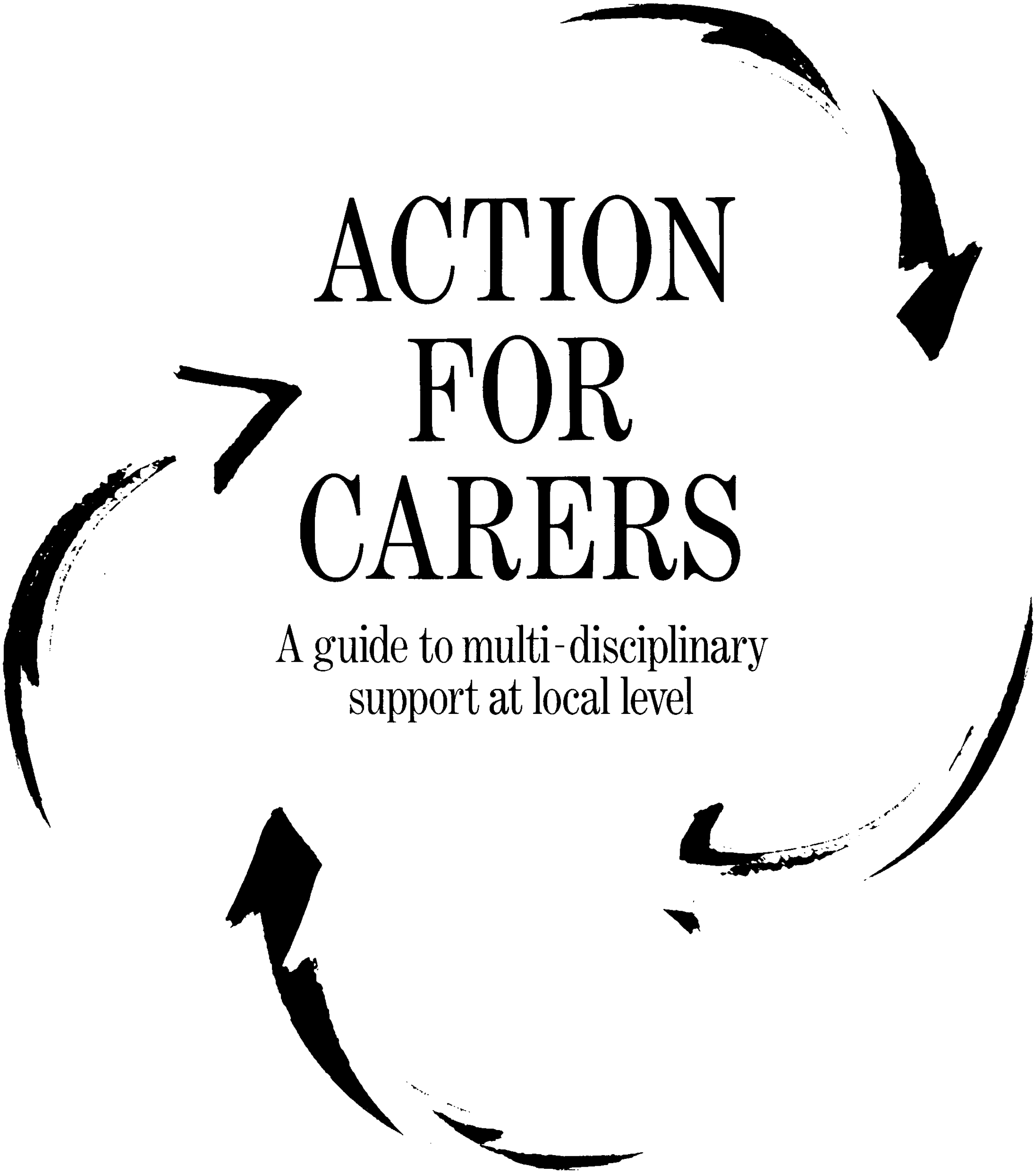
Equal Opportunities Commission (March 1982) *Who Cares for the Carers?* and (April 1984) *Carers and Services*, EOC
The first of these examines the implications for women of current policies as regards community care for the elderly and handicapped. It summarises the effects and costs for carers and makes a series of recommendations on arrangements for support for carers. The second reports a study which compares the circumstances of men and women caring for dependent elderly people, and emphasises the need 'to think very carefully about the problems, rather than in stereotypes'.

Finch, J and Groves, D (Eds) (1985) *A Labour of Love: Women, Health and Caring*, Routledge and Kegan Paul
Consists of papers from a number of prominent researchers, exploring the experiences and the dilemmas of women across the whole range of caring (children, adults, elderly). It opens up for analysis the division of labour in the 'domestic sector of welfare'.

Parker, G (1985) *With Due Care and Attention: a review of research on informal care*, Family Policy Studies Centre, Occasional Paper No 2
Reports an extremely thorough literature review, focusing particularly on 'who, in practice, provides informal care' (in relation to the demographic and administrative background of care in the community), on the costs that may be incurred by carers (financial, social, physical and emotional) and on current patterns of support for carers.

Thompson, C (1985) *Sharing Caring: Caring, Equal Opportunities and the Voluntary Sector*, National Council for Voluntary Organisations
This is a topic paper from the 'Community Care' Project at NCVO. It summarises what community care means for women, what their needs are, and what voluntary agencies can do at local level. It describes a range of projects and intiatives, and raises a number of points for discussion.

Willmott, P (1986) *Social Networks, Informal Care and Social Policy*, Policy Studies Institute
This reports on a research project which examines the capacity for informal care and mutual support 'through networks of mutual relatives, friends and neighbours' against the backdrop of the changing structures of local communities in contemporary Britain. It draws attention to a number of unexpected shifts in the patterns of family and kin contacts, particularly the decline in mutual aid in traditional working class neighbourhoods; and it makes suggestions for policy and practice in community care.



ACTION FOR CARERS

A guide to multi-disciplinary support at local level

Group facilitator's guide to practice development

Contents

Group facilitator's guide to practice development

Introduction

This guide is addressed to anyone who is involved in setting up, organising, leading or supporting a practice development group using the learning materials in this package. It discusses:

- using the learning materials in training sessions
- the facilitator's role and responsibilities
- particular issues a facilitator may need to be aware of in this type of group.

If you are used to running discussion groups you will find most of this material familiar. However you may find it helpful to look at the final section on 'Issues for the facilitator' which are specific to this type of practice development group.

Identifying training needs, selecting participants and localities and initiating the sessions are discussed in the booklet on 'Setting up and running a project'. If you have not already worked through this material you should do so now.

Overview of the learning materials

Aims

The aims of the learning materials are to help participants to:

- raise their own awareness of carers' needs
- work more responsively with carers
- explore methods of consultation, coordination and collaboration that will improve support for carers
- formulate joint recommendations on policy and resource allocation that will improve support for carers.

Content

The learning materials consist of 14 activity based Modules outlined in the chart overleaf.

Each Module consists of:

- *text* containing information and discussion of the central issues
- *activities* to be used by the group. Some of these are aimed at developing insight through discussion, imagination, or a review of practice. Others are aimed at action through planning the development of new skills and practices.

The Modules are arranged on separate sheets, for easy photocopying.

Module number title and themes	**Activities**	**Times**
1 Introduction to 'Action for Carers' *Introduction to the materials and to the action plan activity running through them. Essential Module*		15 minutes to read through
2 The experience of caring *What it feels like to be a carer; the daily routine; common feelings.*	1 Diary of a day – *reflective activity on the experience of caring*	About 15 minutes
	AND/OR 2 If it happened to me ... – *reflective activity on the experience of caring*	15–20 minutes
	AND 3 Group discussion *on Activities 1 and 2*	30–40 minutes
	AND 4 Creating action plans	20–30 minutes
3 The needs of carers *Types of needs carers have, carers' views of services, relationships with workers.*	1 A failure in professional response – *case study discussion*	30–40 minutes
	AND 2 Creating action plans	20–30 minutes
4 Identifying the carers *Statistical information on carers, reasons for identifying carers, problems in identifying carers.*	1 Look at your caseload/ group networks – *examination of reason for and means of identifying carers*	10–15 minutes
	AND 2 Look at your 'patch' – *examination of reason for and means of identifying carers*	15–20 minutes
	AND 3 Look at the borough/ district/county – *examination of reason for and means of identifying carers*	15–30 minutes
	AND 4 Creating action plans	20–30 minutes
5 The role of the worker with carers *Relationships between carers and workers, roles and responsibilities. Useful to combine with Module 3 and/or 8*	1 Job descriptions – *using job descriptions to define work with carers (people need to bring individual job descriptions if possible)*	30–40 minutes
	AND/OR 2 Changing relationships – *exploration of possible changes in relationships with carers*	20 minutes
	AND 3 Creating action plans	20–30 minutes
6 Offering emotional support *The nature of carers' emotional needs, difficulties for workers in meeting them.*	1 Difficulties for workers – *discussion*	20–30 minutes
	AND OPTIONALLY 2 Support networks – *identification of sources of support and ways of improving support*	10–20 minutes
	AND 3 Creating action plans	20–30 minutes
7 Managing your work *Organising work to meet carers' needs; time management; efficiency and effectiveness for carers, clients and the organisation.*	1 Time management check – *preparation activity (to be done before the session)*	20–30 minutes
	AND 2 Time management discussion	About 20 minutes
	AND 3 Creating action plans	20–30 minutes

Module number title and themes	**Activities**	**Times**
8 Collaboration *Definitions of collaboration; benefits and problems of collaborative work.*	1 Critical incidents – *discussion of specific incidents of good and bad collaboration* AND/OR	About 1 hour
	2 Role restrictions – *exploration of the ways roles can change in collaborative work* AND/OR	20–30 minutes
	3 Collaboration snapshots – *active examination of the group's working relationships* AND	30–40 minutes
	4 Creating action plans	20–30 minutes
9 Packages of care *Coordinating flexible, individual packages of care; key worker systems; the package of support approach.*	1 Choosing a model of care – *case study discussion* AND	About 45 minutes
	2 Creating action plans	20–30 minutes
10 Communication *Necessity of good communication; barriers to communication.*	1 Types of contact – *case study discussion* AND/OR	About 20 minutes
	2 Communication maps – *mapping links between workers (needs pen and paper)* AND	About 30 minutes
	3 Creating action plans	About 20 minutes
11 Information *Carers' needs for information; the need for sensitivity in giving information to carers; the need for workers to collaborate by sharing information.*	1 Case study discussion AND/OR	20–30 minutes
	2 Sharing information – *examination of ways the group could share and develop information resources (needs flipchart)* AND	20–30 minutes
	3 Creating action plans	About 20 minutes
12 Statutory/voluntary sector relationships *Collaborative work between workers from the statutory sector and workers and volunteers from the voluntary sector; the role of the voluntary sector.*	1 Case study discussion AND	About 30 minutes
	2 Creating action plans	20–30 minutes
13 Informal networks and neighbourhood care *The need for a critical appraisal of the existence of informal networks; use of neighbourhood care schemes as a substitute for informal network.*	1 Reviewing your patch – *analysing the possibilities for informal networks and neighbourhood care* AND/OR	20–30 minutes
	2 A particular case – *thinking about the opportunities in your patch in relation to a case study* AND	About 15 minutes
	3 Creating action plans	20–30 minutes
14 Implementing change *Understanding processes of change; assessing the feasibility of specific changes.* *Essential Module.*	1 Action plans – *making final decisions on changes to implement as a result of the work done on previous Modules*	1½–2 hours

Selecting from the materials

Modules 1 and 14 should be included in *all* programmes. Module 1 introduces the materials and way of working. Module 14 pulls together the work done in the sessions into an action plan for change to be carried out at four levels:

- individually
- in conjunction with colleagues/line managers
- collectively with other group members
- through recommendations to senior management.

A selection can then be made from Modules 2–13 depending on the time you have available and the needs of participants.

Time In Croydon, practice development groups met for five 1½ hour sessions at lunchtimes. This (or a whole day workshop) is probably a minimum if there are to be any effective outcomes. Longer sessions would allow more time for the development of group trust and cohesion which is vital in multi-disciplinary work. More sessions would also help to do this, as well as increasing the content that can be covered.

Participants' needs You should try to establish these when you first make contact. A group which has low awareness of carers will need to spend more time on the earlier Modules than a group which is already attuned to their needs.

A 'low awareness' group might, for example, cover in five 1½ hour sessions:

Session 1 – Modules 1 and 2
Session 2 – Modules 3 and 5
Session 3 – Module 9
Session 4 – Module 11
Session 5 – Module 14.

A 'high awareness' group could come straight into the section on multi-disciplinary work and cover in the same number of sessions:

Session 1 – Modules 1 and 9
Session 2 – Module 11
Session 3 – Module 13
Session 4 – Module 10 or Module 12
Session 5 – Module 14.

In reality, many groups will have a mixed membership with differing levels of awareness and differing needs. Sometimes it can be helpful to divide into smaller groups in order to meet more needs. In an all day workshop, for example, selected Modules could be 'on offer' for participants to choose from. At other times it is part of the facilitator's task to draw on the range of individual contributions in a way which allows the group to pursue common learning goals despite their differences (see page 9 of this booklet).

You will find that some of the activities in the Modules are aimed equally at workers, volunteers and carers. Others focus on improving the collaborative practices of workers and volunteers in support of carers, and so are more appropriate to these two groups. Carers can usually be included by drawing on their experience and opinions, but you may need to plan how best to do this in the Modules you choose.

Responding to changing needs

In order to plan your programme you will have to assess participants' needs and select activities that you hope will meet them. However, your assessment may differ from the needs people express when they actually arrive. Similarly, people's awareness of their needs can change as they work. Either reason may make your original plans inappropriate. You will need to check out and take account of what people want from time to time, *insofar as this is possible*. It is important to be flexible but also important to maintain a coherent programme. Using the learning materials allows you to substitute a more appropriate activity or Module as required, while staying within the original objectives.

Reviewing your own responses

It will help in planning and carrying out the programme to have read through the materials carefully so you are familiar with them. It will also be useful to think through your own responses to some of the issues they raise, particularly if you have little experience of work with carers. Like the people who come to the sessions, you may discover assumptions and prejudices in yourself that need to be challenged. You will be better placed to help the group do this if you have examined your own attitudes first.

As preparation you might find it helpful to work through some of the activities on your own. Those in Module 2 'The experience of caring', Module 3 'The needs of carers', Module 5 'The role of the worker' and Module 8 'Collaboration' are likely to be particularly useful.

Running the sessions

Running discussions using structured learning materials requires two rather different roles of the facilitator. In the initial stages your role is to organise, structure the sessions, and decide which materials to use on the basis of what you can find out about participants' needs. In the sessions themselves, however, your role should be enabling rather than didactic, sharing responsibility with group members rather than determining what happens. Your aim should be to use the materials to develop open discussion, with as much participation as possible from all group members.

Getting started – the first session

Your aim in the first session is to help people to feel relaxed, interested and willing to participate. Good discussion depends on people being open with each other and sharing problems, uncertainties and weaknesses as well as ideas, plans and opinions. Multi-disciplinary work also depends on relaxing boundaries and dropping differences so your programme should try to help create this open climate. An informal setting with comfortable chairs arranged in a circle will set the tone better than a formal teaching situation. Your style and attitude as facilitator is crucial. If you can be open, relaxed, interested and enthusiastic this will give permission for other people to be so as well. Defensiveness and reserve on your part will not give people confidence and will tend to make them defensive too.

Start the first session by outlining briefly the programme you have planned and the reasons for it. Then use any of the formats below or ideas of your own, to help people introduce themselves. One name remembering game followed by a paired exercise often works well.

Name remembering games You need a child's ball for the first of these. Sit in a circle, say your name and throw the ball to someone whose name you don't know. They say their name and throw the ball on. Carry on until everyone seems to know each other's name. Repeat with name and role (for example GP, social worker) if you wish. Alternatively, go round the circle in the following fashion. The first person says their name, for example 'I'm Jane.' The second person repeats the first person's name and their own, for example 'This is Jane and I'm John.' The third person repeats the first two and then their own and so on round the circle till the last person repeats everyone else's. This can be nerve-wracking for those near the end and so needs to be done in a spirit of humour and helpfulness for those who forget.

Paired introductions Ask each person to take a partner they don't know, or don't know well, and talk about themselves and their work for three minutes each. Each person then introduces their partner to the rest of the group.

Paired expectations As above, but ask people to talk about their expectations of the programme. Go round the circle asking each person for *one* of their partner's expectations and write these up on a blackboard or flipchart. Go round again for any additional expectations. Give feedback about how far what you have planned is likely to meet people's expectations and offer to negotiate content if your programme seems off beam and it would be possible to substitute other Modules. Keep the lists of expectations to refer back to in later sessions. They can be useful for looking at changes in people's ideas of what they want and for evaluating the programme at the end.

An alternative is to ask for 'hopes and fears' rather than expectations. This can be useful for bringing out people's doubts but may depress excitement. Give feedback on what you see as realistic and unrealistic and what may be problems for the group to work on.

Getting started – the following sessions

In subsequent sessions you may find it helpful to start by going round the group asking each person to contribute briefly on a theme that connects back to the previous week's work. For example:

- something I've done differently with a carer
- an idea I've had about my work with carers
- something I've done to improve my work with carers
- something I've put into practice from last time.

Running the discussion

As facilitator you have five main responsibilities:

1 Setting group norms Groups tend to carry on in the style in which they start. Good beginnings are critical. It can be helpful to state some basic ground rules at the beginning, for instance:

Confidentiality If people are to be open with each other then they need to know that what they say will not be gossiped about outside the group.
Commitment Trust and collective work depend on the group having a stable membership, so ask people to make the commitment to attend regularly and on time.
Dropping 'official hats' It will help if people can feel they are there as themselves rather than as representatives of the organisations they work for,

responsible for all its sins and omissions – including pride.

You can also help to set appropriate group norms by your own style and behaviour.

2 **Modelling behaviours** Everyone has their individual style of working with a group. Some people are naturally quiet, others naturally confrontative. The following behaviours are usually helpful in creating a good discussion group. If the facilitator 'models' them, fitting them round his or her natural style, other group members are likely to follow this lead.

Listening attentively, not interrupting, responding positively to other people's contributions.
Giving support to individuals by validating what they say, helping them to express something.
Refraining from judging, criticising, moralising or dismissing people for their views. This tends to back people into corners and inhibit open discussion. It is usually more helpful to discuss the implications of an unpopular viewpoint or examine what lies behind it.
Confronting evasiveness, defensiveness and dishonesty in a non-judgemental way, allowing room for the person to reflect and change their position rather than be shamed for it.
Giving permission for the sort of discussion you want – for instance making it clear through your encouragement that it is all right to broach difficult issues, admit to weakness, have 'unprofessional' feelings.

A useful rule of thumb is to *look for what isn't there in a group and try to supply it.* For example, a cosy group will need you to be confrontative, an explosive one will need you to be calm, a quiet group may need an input of energy and so on.

3 **Involving people** Many of the activities are structured so that everyone has to be involved. Despite this you will probably find that some people are quiet while others dominate. In the paired activities it will help initially to partner people with those they don't know well and subsequently to make sure that people change partners. Individual contact usually helps to build trust and confidence in quieter people. Asking quiet people to speak in a group is not usually effective as they feel put on the spot and embarrassed. Instead, try looking for people who are about to speak but have difficulty getting in and create a space for them; invite quiet people who do say something to expand on their point.

4 **Covering the ground** It is up to you to ensure that the group covers the material as effectively as possible in the time available. It can help to:

- feed back your perception of the discussion
- ask 'awkward' questions and challenge cherished assumptions
- make connections and pull arguments together
- draw attention to points that may have been missed
- summarise and draw conclusions
- focus on possible outcomes.

5 **Setting the pace** You will need to use your judgement to keep the group within the broad time limits available. Sometimes it is helpful to let a lively discussion overrun and drop another activity you had planned. At other times it may be more useful to push for conclusions. If interest is low and the pace flagging, you may need to suggest a different activity. Make sure you end on time.

Endings and follow up

In the final session (or final two hours of a workshop) you should use Module 14 'Implementing change'. This focuses on conclusions and outcomes and should help to draw the sessions to a satisfactory close. You may also find it helpful to conduct a brief evaluation and to arrange a follow up session.

Evaluation A written evaluation will help you to judge the success of your programme and to plan future programmes. A single sheet of A4 with a maximum of six questions is all that is needed (and all that people will usually fill in). Questions you might ask are:

1 What have you found most useful?
2 What have you found least useful?
3 In what ways (if at all) have the sessions changed your thinking?
4 In what ways (if at all) have the sessions helped you to work better with colleagues to support carers?
5 Please comment on:
a) the materials
b) the format of the sessions
c) the leadership and organisation.

An evaluation discussion will also help the group to end well. It may pick up any unfinished business as well as giving you feedback on the success of the sessions. Divide into pairs and ask people to talk about:

- the thing they liked least and the thing they liked best about the sessions

or

- their best and worst moments from the sessions

or

- the thing they found most helpful and the thing they found least helpful for their work.

Feed back the information to the whole group with each person speaking for their partner. Asking for opposites usually helps people to voice their criticisms and reduces the tendency for bland, polite responses. Asking partners to feed back helps avoid the tendency to tailor responses so that they agree with the majority.

Follow up The action plans people create in Module 14 may require further meetings so allow time for these to be planned. People may also want a follow up meeting to report on what they have done individually and to get group support.

Issues for the facilitator

The subject matter and membership of groups always throw up particular dilemmas for the facilitator. Those discussed below occurred in the Croydon practice development groups. They are likely to be issues for any group working on the subject of multi-disciplinary support for carers.

The inclusion of carers

As discussed in the booklet 'Setting up and running a project', there are strong arguments for including carers in practice development groups. Nonetheless there may be difficulties in their inclusion. If it is decided in planning the programme to include carers, they need to be carefully briefed on what to expect and what may be asked of them.

It may also be useful at the first session to discuss what carers and workers hope to gain from the others' presence. If problems occur during the sessions it may help – as with any other difficult issue – to present them to the group as something they should own.

Existing professional relationships

Existing professional relationships can play havoc with attempts at openness in a practice development group. As facilitator you need to be aware that many relationships in the group will have a past history, maybe good, maybe bad. People may be cautious because of past experience. There may be unresolved anger or mistrust over failed attempts at referral or collaboration. People may fear that others will reveal things they would rather keep quiet about. Junior staff may be wary of being critical in front of senior staff. Senior staff may feel inhibited from expressing doubts or weaknesses in front of junior staff. There may be a tendency for people to hide behind professional boundaries and also to defend and feel responsible for the general deficiencies of the organisation they represent.

In the early sessions it will help to invite people to 'drop their official hats' and to see people for themselves rather than as representatives of organisations. As the group develops and you are dealing with the Modules on multi-disciplinary work, you may find opportunities to confront and deal with the issues that arise from existing relationships.

Conscripts vs volunteers

In Croydon, some staff were instructed to attend and turned up regularly. Others had more choice over whether or not they attended and some of these people were less reliable. 'Conscripts' may need to be won over initially and helped to feel ownership of the group. 'Volunteers' may start with lots of enthusiasm but will soon disappear if they don't get what they want. It will help to emphasise when you invite people and at the beginning of the group that regular attendance is necessary if any effective work is to be done. However, keeping people coming back depends on the quality and usefulness of the group experience. It will help to check regularly whether participants are finding the work of the group useful and appropriate, and to modify the programme accordingly.

If people are not happy, they will vote with their feet – literally if they are free to do so and by withdrawing and not contributing if they are unwilling attenders.

Differences in group experience

In any group there will be differences in how much at ease people feel in contributing to a group. In Croydon these differences were quite marked. For some carers and some people from the voluntary sector the experience was a completely new one and they needed a lot of reinforcement and support to contribute. At the other extreme people from social services were used to working in groups and could handle a faster pace and more confrontative style.

It is important to be aware of such differences, and not try to handle them alone. As facilitator you cannot possibly meet demands for slow gentle work and fast confrontative work both at once. This kind of problem can only be solved by handing it back to the group to deal with. You can do this by:

- structuring the group so that experienced people partner less experienced people in paired activities partner less experienced people in paired activities

- commenting on the process, for example 'We seem to be excluding some people from the discussion at the moment. Is there any way of bringing them in?' This passes responsibility for what is happening back to the group
- acknowledging different needs and suggesting dividing the time or dividing into smaller groups.

If the group is going well, trust and confidence will develop and minimise these differences in experience. More experienced people take over an enabling and supporting role with those who are less experienced and the less experienced will become more confident and participate more freely.

Module 1 Introduction to 'Action for Carers'

Background

The learning materials you will be using were developed from work carried out in Croydon in 1986/7 by the London Boroughs' Training Committee, on the project 'Multi-disciplinary support of informal carers'. This project was funded by the King's Fund Informal Caring Support Programme. The materials are part of a larger package entitled 'Action for Carers' which can be used to develop multi-disciplinary work in support of carers at a number of levels within the professions and agencies concerned.

The Modules you will be working on are aimed primarily at practitioners. They have been developed from the work of two 'practice development groups' set up in Croydon to explore ways of improving collaboration amongst people who work with carers. All the quotes are taken from carers and practitioners in Croydon and reflect their experiences of trying to work better together.

Aims

The aims of the Modules on 'practice development' are:

- to raise awareness of the needs of carers among people in the statutory and voluntary sectors whose work brings them into contact with carers
- to help these people work more responsively with carers
- to explore methods of consultation, coordination and collaboration that will support carers more effectively
- to develop and carry forward inter-agency policy recommendations that will improve support for carers.

Using the learning materials

The learning materials are designed for use by groups of people who wish to improve the way they work together to support carers. Such a group might include paid workers from health, social services and the voluntary sector, members of voluntary organisations and carers themselves.

The materials are divided into 14 Modules.

- Module 1 'Introduction' and Module 14 'Implementing change' form a framework to the other Modules and should be done by any group using the materials.
- Modules 2–7 focus on the carer's experience and needs and the role of individual workers in meeting these.
- Modules 8–13 deal with the importance of collaborative work in meeting carers' needs and explore the problems and difficulties involved.

The facilitator for your group will work out a selection of materials with you, depending on your needs and interests and the time available for group meetings.

What you will have to do

The materials are based around activities, some of which you will be asked to do in group sessions and some at work or at home. In the sessions you will usually be asked to read something and then explore your response to it through discussion with other group members.

Some activities ask you to explore your attitudes and feelings about the work you do. Some ask you to analyse existing organisational relationships and assess their effectiveness. Some require you to find out something or monitor your own work in between sessions. Some ask you to imagine and plan ways of working differently. In all these activities it will help if you are able to drop your 'official hat' and talk honestly and openly about the realities and problems of work and caring.

At the end of each Module you will be asked to fill in ideas for action on the charts overleaf. Detailed instructions for doing this are given on the next page.

In the final Module 14 'Implementing change' you will be asked to create an action plan for yourself and for the group and set a timetable for what you intend to do.

Creating action plans

You will find that the last activity in each Module asks you to fill in column 1 on each of the four charts overleaf. It is very important that you do this or you may find that the sessions leave you with a feeling of 'so what?'. You also need to do this in order to be able to complete Module 14 'Implementing change'.

The idea is to build up a bank of possible ideas for action which can be drawn on in the final session when you create your action plans. At this stage you do not need to think through the implications of any of the ideas. Include things you feel uncertain about, might like to discuss further, suspect might be unrealistic or do not know how to implement.

When you create your action plans in Module 14 you will sift through the ideas you have collected, consider how interested you are in them and how easy the changes would be to make (Columns 2 and 3). Then you will plan ways of implementing the ideas most likely to succeed. For now, leave columns 2 and 3 blank.

It will be best to generate ideas for Charts 1 and 2 in pairs. If you then share all the ideas in the group you can add other people's suggestions to your chart if you wish. When you discuss ideas for Charts 3 and 4 in the group, note on your copy just those that interest you. Some ideas may need to be entered on more than one chart.

How to fill in the charts for Modules 2–13

Think about the ideas you have been discussing in each Module.

In pairs generate:

1 Ideas for action that you could each take as individuals

Some examples people in Croydon gave were:

2 Monitoring their own attitudes and behaviour with carers.
Visiting a local carer's group.
3 Reviewing their approach to a case with a carer.
4 Establishing how many cases they had which involved a carer.
8 Attending case reviews when invited.
11 Preparing information handouts for carers about particular aspects of care.
Compiling a list of voluntary agencies in my patch.
13 Ensuring clients and carers are aware of local societies and organisations that can help.

2 Ideas for action that could be taken within your profession/organisation that you need to refer to your colleagues/line manager for action or permission

Some examples people in Croydon gave were:

3 Setting up training days for carers.
Developing induction training for home helps about carers' needs.
5 Discussing possible changes to my job description to increase work with carers.
6 Setting up a support group for carers.
Getting more funding for Crossroads.
7 Lessening the caseloads of home care organisers so they can undertake development work with carers about their needs.
11 Producing publicity material to inform carers of what is available.

In the group generate:

3 Ideas for actions that people in the group could take collectively without reference to line managers

Some examples people in Croydon gave were:

5 Invite carers to attend case reviews.
8 Quicker coordination between agencies involved in a case.
Promotion of carers' problems within each service.
Meet regularly with social worker and home care organiser.
Arrange a joint visit to a carer.
9 Prepare a report for senior management across the services on the need for a key worker system.
10 Liaise with the health visitor.
11 Produce a carers' information pack.
13 Liaise with the Guild of Voluntary Organisations. [CVS]

4 Ideas for actions that need to be taken at policy level (senior management) across the professions and organisations

Some examples people in Croydon gave were:

3 Setting up a mixed age group drop in day centre.
Setting up a care attendant scheme for the elderly.
Providing more respite care and different respite options.
9 A review of respite care.
Appointing a carers' worker.
Establishing a key worker system.
11 Funding an information and resource pack for carers.

For your own reference enter all the ideas that interest you in column 1 of each chart, alongside the relevant Module number. Leave columns 2 and 3 blank for now.

Action charts

For each Module, enter all the ideas for action that appeal to you in Charts 1–4.

Chart 1 Individual actions now

Module number	(1) Ideas	(2) Degree of interest	(3) Ease of change

Chart 2 Actions for colleagues or line managers

Module number	(1) Ideas	(2) Degree of interest	(3) Ease of change

Chart 3 Group actions now

Module number	(1) Ideas	(2) Degree of interest	(3) Ease of change

Chart 4 Policy actions for senior management

Module number	(1) Ideas	(2) Degree of interest	(3) Ease of change

Identifying the carers

Why identify carers?

At a borough or county level, identifying carers can help to inform strategic planning and the development of services.

At a patch level, identification can help in developing appropriate projects, raising awareness, targeting information, improving collaboration or eliminating duplication of services.

For individual workers, identifying carers on their caseloads is the first step towards providing an appropriate service within the resources already available. It may be helpful to look at questions like how long people have been carers, the kinds of people cared for, whether care is likely to be short or long term and what needs the carer has.

Any proposal to identify carers may create anxiety among service providers that the process of identifying previously 'hidden' carers will lead to increased demands on already overstretched resources. Against such anxieties must be weighed the need to understand and meet changing demands on services and the moral necessity of developing ways of responding more effectively to a group who, in general, provide much and ask for little.

Problems of identification

Local projects which have set out to identify carers have often found this difficult for a number of related reasons:

Professionals may fail to identify carers because their focus is the person being cared for and the carer's role is not recognised.

Carers may fail to identify themselves through feelings of pride or independence or simply not knowing that such a role label exists or applies to them.

Isolation – tied to the person they care for, carers may not come into contact with the people, organisations or information that might help them to define what is happening to them as a 'caring' problem rather than an individual difficulty.

Gender role – the cultural expectation that wives and daughters will perform the caring role may lead women not to identify themselves as carers.

Many of these problems are intensified in locating *carers in black and ethnic groups.* Because of cultural expectations they may be unlikely to identify themselves as carers. Equally, there may be:

- false assumptions by workers that carers in black and ethnic groups choose to care for their dependants and are supported by extended families
- language barriers
- a lack of knowledge about or confidence in approaching appropriate agencies
- difficulties in gaining recognition even when needs are identified.

Who are the carers?

In the absence of a nationally representative survey, knowledge about the numbers and characteristics of carers is unreliable. The figure usually given is of at least 1.3 million carers in Great Britain, the majority of whom are women.

Recent research by the Policy Research Unit at Tameside Metropolitan Borough looked at a random sample of 17,000 households, followed by a survey of 800 households containing a carer. Eleven per cent of households in the random sample said they were carers or undertook caring tasks for friends or relatives. Extrapolated nationally this gives a figure of nearer five million. Further breakdowns of the figures suggest that nearly 20% of all adults in the 45–54 age group are carers and that 1 in 4 of all adults will be a carer at some point in their lives. (A report on this research will be ready in April 1988 and can be obtained from: Policy Research Unit, Room 6.14, Tameside Metropolitan Borough, Council Offices, Wellington Road, Ashton-under-Lyme OL6 6OL).

Strategies for obtaining information

Information on the numbers of local carers and their needs can be gained by:

1 formal screening projects carried out by health authorities or social service departments, separately or together

2 analysis of routine professional records, eg:

- identification from records in primary care held by GPs, health visitors and community nurses (especially if age/sex registers are maintained)
- social work assessments
- discharges from hospitals

3 local surveys by specialist organisations, such as that described in *Who Cares in Southwark?* (Bonny, S (1984) Association of Carers)

4 action research projects such as that undertaken by the HEC in Cambridge (Rosie Bell, Sue Gibbons, Ian Pinchen, (1987) *Action research with Informal Carers of Elderly People: patterns and processes in Carers' Lives*, Health Promotion Service, Cambridge)

5 raising public awareness through the local media and information displayed in places that are used by carers such as day centres, surgeries, chemists and post offices

6 using contacts with key people in existing organisations, including carers' groups and local branches of specialist organisations

7 approaches to black and ethnic groups using the relevant newspapers, meeting places and personal contacts, initially with key people (some translation services may be needed).

Group activities

All four activities should be done.

10–15 minutes

1 Look at your caseload/group networks

In pairs discuss what you might do as individuals to identify carers. This might involve looking at your caseload if you are a professional worker, at the role of your organisation if you are from a voluntary organisation, or at the networks you are part of if you are a carer. Think about:

- What do you already know about the existence of carers in your caseload/area?
- What could you do to identify carers?
- What could you do with this information?
- What demands might identifying carers bring upon you?
- What ethical questions are raised by identifying carers? For instance, should you identify needs you may not be able to respond to? What information should you share with others?

20–30 minutes

4 Creating action plans

Refer back to Module 1 for instructions and fill in your individual charts.

15–20 minutes

2 Look at your 'patch'

Divide into patch based groups People who are not patch based can be allocated randomly to the groups. Discuss:

- What projects already exist in your patch that work with carers?
- What projects in your patch might have information about or access to carers?
- What more could be done in your patch to identify carers? Why should this identification be done? Who could and should do it? What part would the people present like to play?
- What ethical questions are raised about sharing information?

15–30 minutes

3 Look at the borough/district/county

In the group discuss:

- What major identification strategies would you like to see adopted? Why? How would they help carers? How would they help workers?
- What staff, time and money would be needed to pursue these strategies?
- Whose responsibility is it to pursue these strategies and how can they be convinced of the necessity?

The experience of caring

Carers' experiences

Carers are ordinary people who do an exacting and exhausting job. They care for people of differing ages with a range of illnesses and disabilities.

In the right hand column is the diary one carer kept of a typical day. She was caring for her elderly mother who had had a stroke and could not get in or out of bed, on or off the commode or manage her clothing without help.

Although each carer's experience is unique, there are many common feelings. For example:

Loneliness and isolation
'There is no opportunity for female company at all. There is no one to cuddle me when something goes wrong.'

The lack of choice
'There's nobody else to do the job. I am his wife.'

Grief and loss
'A desperate sadness that a good life – and a super son – cannot be had by him.'

Frustration at being tied
'The worry is always there, you cannot leave it behind ... if you are away, even for a day, you have to hurry back.'

Anger
'I feel very angry at times – the "why me" syndrome.'

Guilt
'He sees me down and says "I should be in a home" and then I feel guilty.'

Stress
'At times you could scream ... when father gets into tempers and hits out with anything available ...'

Rewards
'I'm very thankful I was able to care for my mother in her own home at the end of her very long life.'

Morning
Start at 7 am with call from mother to use commode.
Remove my bedding and mattress from the hall. (I sleep here in order to avoid falling on the stairs in the night when attending to mother.)
Help my mother to wash and dress and get her to walk with aid of zimmer to front room.
Get some breakfast for us both.
Mother then needs to use commode again.
Wash and dress myself.
Make my mother's bed, air the room, empty commode etc.
Wash my mother's soiled clothing and make sure of sufficient dry clothing for next day – or next time needed, possibly same day.
Mother will then need to use the commode again. This happens about every two hours, give or take a little. As she cannot get out of her chair without help and dare not let go of zimmer in case she falls down she has to be attended and toileted the whole time, and this is quite a time-consuming operation.
Make hot drinks and a light lunch for us both.

Afternoon
I either do housework or a little tidying up in the garden, *or* go to local shops for necessities, *or* go to Croydon to pick up incontinence supplies.
Make tea for us both and try to get my mother to try and peel potatoes and carrots while I prepare and cook evening meal.

Evening
The phone rings just when the food is ready. Either ignore it or tell the caller I'll ring back.
After the meal, wash up while mother falls asleep in front of TV.
Either fall asleep the moment I sit down because the only time I've sat down during the day was to eat, or telephone people who are trying to contact me.
When mother arouses because of quiet spell on TV make moves to get her to bed.
Prepare her room for easy access during night.
Make up my own bed on hall floor and try to get some sleep before broken night begins.

Group activities

Either or both of the first two activities can be done as a lead in to the third. Finally, complete Activity 4, 'Creating action plans'.

About 15 minutes

1 Diary of a day

Individually Compare the carer's diary overleaf with some other experiences of caring that you are familiar with, for example:

- your own experience of being a carer
- the day of a professional social worker, doctor or nurse
- the work of a care assistant in a Part 3 home
- the work of a nursing assistant in a mental handicap hospital
- the day of a parent at home with small children.

Try to draw out what is similar and what is different in each situation so that you can see the particular stresses a carer may be under. For instance, you might feel that the exhaustion is similar to that of a parent at home with small children but is different because the carer is faced with deterioration not development, and with a loss of hope rather than with pleasure at new abilities. Note down your ideas for contribution to the group discussion.

15–20 minutes

2 If it happened to me ...

Divide into pairs Think for a moment about your immediate relatives (parent, spouse, sibling, child) and imagine what might happen if one of them became dependent through illness, disability or old age. Take turns to talk for five minutes about:

- What would be likely to happen?
- Would you become the carer? If not, who would? Think about how this would be decided. What assumptions are involved about issues like women's and men's roles and responsibilities?
- How would your life change as a result?
- How do you think you might feel at the time? Six months later? A year later?
- What help would you hope for – from friends/relatives and from professional/voluntary services?

If you are or have been a carer you can best contribute to this discussion by describing what actually happened to you.

30–40 minutes

3 Group discussion

As a group share the ideas and feelings which came up in each activity. Discuss any themes which emerge, for instance:

- How easy/difficult is it to identify with carers if you have no experience of caring yourself?
- Why do/don't you back off caring?
- What are the physical and emotional stresses of caring?
- How can workers, volunteers, friends and family best respond to the feelings generated by the experience of caring?

20–30 minutes

4 Creating action plans

Refer back to Module 1 for instructions and fill in your individual charts.

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The needs of carers

What carers want

National and local studies of carers have identified the following main areas of need.

Information and advice about caring Carers may need:

- detailed knowledge about the diagnosis and progress of the dependent person's condition and, as far as possible, the prognosis: what to expect
- guidance in facing and resolving the personal issues involved in deciding whether or not to assume the caring role
- information on what services are available and how to get them.

Assessment and review Carers may need:

- early assessment of the dependent person by relevant and identifiable people whose role they know
- to be included in the preparation of a care support plan with all involved, including the dependent person if practicable
- ongoing review – carers' needs change as do those of the people they care for.

Financial support Carers may need:

- advice on the financial support available to them
- help in getting it
- advice on the provision/cost of private help.

Training Carers may need:

- guidance on practical aspects of care such as lifting, feeding, toileting
- guidance on psychological aspects of care such as depression or mood swings in the person they care for, and how to respond to them
- guidance on ways of reducing stress and tension
- advice on managing on a reduced income.

Help in the task of caring Carers may need:

- aids and adaptations in the home to help the person they care for
- help with tasks such as bathing, lifting and cleaning
- an occasional sitting service for visits to the hairdresser, dentist, family or friends, etc
- day time relief such as a care attendant, day centre, or hospital care
- night time relief such as a putting-to-bed service or night time sitting service to enable carers to have an unbroken night
- longer respite care appropriate to needs
- emergency respite care to cope with crises.

Emotional support Some needs for emotional support may be met by family and friends, but carers may also need more organised support such as:

- a befriending scheme
- individual counselling
- a carers' support group.

The major factor which emerges from these surveys is that carers need varied, flexible and reliable services which take account of their particular personal and social circumstances and can adapt to their individual and changing needs. Information needs to be appropriately timed and advice presented in an acceptable way. Particular attention needs to be paid to these points by people working with carers whose backgrounds are very different from their own. People from black and ethnic groups, for example, are particularly likely to receive inappropriate or inadequate services as a result of false assumptions or prejudice on the part of workers.

Relationships between carers and professionals

Recent studies have clarified carers' needs, but have said little about the extent to which professional and voluntary workers are aware of those needs. It is likely that their awareness of carers' needs will vary according to:

- their role and the nature of their contact with carers
- their training and its emphasis on 'patients', 'clients' or 'the family'
- individual awareness based on personal experiences of caring
- the general approach/priorities of their agency/ service
- the further training they have undertaken.

One professional worker who had cared for her own mother for ten years concluded: 'No professional will *ever* understand till they experience it – day in, day out. Maybe I sound different, it's not just professional talk, you can't expect to know till you've done it. Then you are able to understand the tiredness, the hardness of doing it, in a way that you can't in an eight hour day.'

In general, carers in Croydon appreciated the services provided. GPs were valued for providing information or referrals and were seen as a source of support who would visit regularly and could be contacted when problems arose. Nurses were valued for their practical care, their willingness to listen and their role in obtaining aids and appliances. Support such as the Crossroads Care Attendant scheme, which can reliably replace the carer, was particularly valued: 'Without the support of Crossroads I think I would've given up years ago.'

This appreciation needs to be qualified however. Because they are so busy, both doctors and nurses could and did prevent carers from saying what they felt or needed:

'Everyone knows we exist but we're good at not being pestered by people's problems ... it's the *way* we ask carers how they are ... they think we're very busy ... we're very good at being busy!' (GP)

'They know we're busy, rushed ... they can't antagonise us because they're dependent on us.' (Nurse)

Frustration and anger were also common and powerfully felt by carers:

'No one *told* us anything – but we picked things up, worked our way through ... we weren't *told* that if he fell there was an ambulance service that would come and pick him up again.'

'It took six phone calls just to get through to the home help service and then they told me the person I had to speak to was in a meeting ...'

Carers' difficulties in seeking help are real and need consideration. They range from feelings of stigma and fears of being seen as not coping, to frustration, incomprehension and exhaustion at being unable to contact the right service at the right time. One senior manager in social services acknowledged: 'We're not good at helping them know what they are entitled to.'

Contact may also be viewed quite differently by a carer and a professional. For example, one carer wished that 'the 'Social Services' would call to *see* if any help were needed such as respite or aids. If you don't get in touch with them they don't want to know, you feel as though you're rejected.' A social worker, however, felt that the twice-yearly call which was all that resources would allow was probably '... a meaningless exercise for the person being visited.'

Feelings about services clearly vary from one carer to another. This points to the need to involve and consult carers in any attempt to assess, define and respond to their needs. Although some may wish to be seen as clients of a service, others will prefer to be seen as partners or co-workers in the care of the dependent person. Appreciating the carer's feelings about their role, and negotiating an appropriate relationship for them, can be very important in supporting them in their ability to care.

Overlap of roles

Overlap of roles between worker and carer can occur through attempts to share care and involve the carer as an equal or senior partner.

Overlap can also occur because, through necessity, carers are being taught tasks which were once regarded as the sole domain of professional workers such as nurses and physiotherapists. For example, in Croydon a physiotherapist visits a person with multiple sclerosis every six weeks to give exercises which both the carer and the dependent person value. The carer has been trained by the physiotherapist to do the exercises at other times and recognises that this reflects a lack of resources. At times, however, the carer finds the exercises a strain and the responsibility a source of anxiety: 'His muscles change in six weeks. I could be doing something wrong and aggravating the situation rather than helping it.'

In both situations the boundaries between caring tasks and professional responsibilities need to be considered and any ethical dilemmas thought through.

Group activities

First consider the case study (right). Then move on to discussing local action plans.

30–40 minutes

1 A failure in professional response – case study

Individually read the case study (right) and list the needs you think Mr and Mrs Jones may have had.

In pairs or as a group discuss:

- In what ways did the professionals fail to meet Mr and Mrs Jones' needs?
- What actions might have produced a better response? Think about:
  - attitudes towards carers
  - racial stereotyping
  - systems and organisations
  - communication
  - planning.
- What is the best outcome you can imagine professionals achieving in this case? What is the worst?

Moving away from the case study:

- In general, what difficulties do professionals have in defining and responding to carers' needs?
- Who should be responsible for assessing a carer's needs? Carer or professional?
- What are the differences between carers' needs and those of the person cared for?
- Who should be responsible for responding to carers' needs once they are defined?
- How do carers' needs differ according to factors such as age, sex, family and social networks, personality and the nature of the dependent person's needs?
- What should be done if no one feels it their responsibility to respond to a need?

20–30 minutes

2 Creating action plans

Refer back to Module 1 for instructions and fill in your individual charts.

Mr and Mrs Jones – a case study

Mr and Mrs Jones are in their early 20s. Their first child, Maxine, was born six months ago severely mentally and physically handicapped. The prognosis is poor. It is unlikely that Maxine will walk, talk or even be able to feed herself.

Mr and Mrs Jones are both children of Jamaican parents who came to England in the 1960s. Mrs Jones' parents returned to Jamaica some years ago. Mr Jones' parents live locally but they have little contact.

It is unclear exactly what information has been given to Mr and Mrs Jones about their daughter's condition. The paediatrician involved believes that telling the parents of a poor prognosis might result in them failing to nurture and stimulate their child.

After Maxine was taken home by Mr and Mrs Jones, they were visited by the midwife before the health visitor started her statutory visits. In addition to the health visitor, the paediatrician requested that a physiotherapist should visit to instruct Mr and Mrs Jones in exercises to prevent deterioration in Maxine's physical condition. The health visitor felt that working with this family was beyond the scope of her expertise so she referred the family to the Community Mental Handicap Team. A joint visit was made by the team's social worker and a community nurse. The community nurse continued to visit weekly with a view to beginning the 'Portage' early education scheme with Maxine and her parents.

At the time of Maxine's birth, information concerning her condition was passed to the Coordinating Medical Officer (Child Health), who informed the Education Department of Maxine's existence. In line with their policy of early contact with parents of children likely to require special education, the Education Department made a referral to their peripatetic teacher who visited the family on a regular basis and provided them with a number of stimulation exercises to undertake with Maxine on a daily basis. Mr and Mrs Jones were expected to attend monthly with Maxine at the paediatrician's outpatient clinic.

Professionals involved with the family began to report that Mr and Mrs Jones were uncooperative. There was particular concern about Mr Jones who seemed very depressed and had taken a lot of time off work. In response to this the community nurse referred Mr Jones to the social worker in the Community Mental Handicap Team to discuss his problems and to consider some form of counselling.

The social worker visited the family. While he was discussing the situation with Mr Jones the peripatetic teacher arrived. Mr Jones's reaction to this interruption was to throw out both the social worker and the peripatetic teacher. He said that he would not tolerate any further visits from any professional.

Offering emotional support

Meeting carers' emotional needs

Carers give a great deal to another person and may receive little. Even when several agencies are providing support, carers often feel unknown because their personal experiences and feelings remain unheard and their emotional needs remain unmet. They may need:

Someone to talk to Many carers need 'to talk to someone' who will accept their feelings. This can be a family member, friend, volunteer or worker.

Counselling Some carers need counselling rather than just a sympathetic listening ear. Sometimes it is helpful if the counsellor has specialised knowledge – for example about the illness of the person cared for.

Help in setting limits Carers may need help to set some limits on the care they give, and they appreciate workers who help them do so.

Meetings with others Carers welcome the chance to meet other carers. This could be at a carers' support group or on an individual basis. It can be particularly valuable to meet other carers who are experiencing similar situations. 'It's important to talk to someone in the same situation – very, very helpful ... most of us are very isolated.'

This opportunity to meet other carers could include more focused learning about a specific condition such as schizophrenia where this is relevant.

Crisis help for dealing with unexpected or exceptional events, such as a young son's violent attack on his mother or a husband's respiratory difficulties. Knowing that a crisis line exists can itself be a source of support.

Help in ending caring Some carers need help in negotiating the end to care. Others need support when caring stops. 'When the caring finishes there's just a dirty, big hole.' Help in rebuilding their confidence and their lives may be needed.

Help in 'disengaging' Some carers may need skilled help in 'disengaging' so as to allow the person they care for more independence.

Everyone who forms a part of a carers' network of support can contribute to their emotional needs in some way. This can be by accepting their anger or providing reassurance. It can be by sensitivity, warmth or by having the time to ask the questions and listen to the answers. Sharing humour can help too. Practical help which enables carers to have time for themselves and which diminishes or removes their responsibilities and concerns, is also crucial. Whatever help is offered should be reliable, responsive and consistent.

Difficulties for workers

Workers can – and do – experience difficulties in relating to carers' emotional needs. Difficulties may arise from:

Lack of time Workers experience pressure to keep to a work schedule, and meet other clients' needs.

Carers' anger and bitterness at the poor service or the situation in which they find themselves. 'There's a lot of anger out there and professionals can't cope with it ... it's the system and the training they've had.'

Unrealistic expectations of provision Carers may expect more help than can be provided. 'It can be very easy for professionals to give too great expectations.'

The effect of carers' 'neediness' on workers, particularly when they are unable to provide as required. Workers feel powerless when they are unable to meet carers' needs.

The carer or cared for person is 'difficult' Some clients may leave the worker with little time or energy to spend with the carer. At times it is the carer who is felt to be 'difficult' by the worker.

Social attitudes or prejudice towards particular carers or clients, for example a person with AIDS, which prevent support being given.

Inability to understand or respond to the carer's experience. This may be due to a lack of appropriate training or to insensitivity.

Group activities

Activity 1 should be done before completing Activity 3 'Creating action plans'. Activity 2 (opposite) is an optional extra.

20–30 minutes

1 Difficulties for workers

In pairs take it in turns to talk for five minutes about:

- the carer I have found most difficult to give emotional support to
- the carer I have found it easiest to give emotional support to.

Try to listen without making judgements. Encourage your partner to explore how they felt and to think about the reasons for their feelings.

In the group discuss:

- What seems to make it easy/difficult to give emotional support to a carer? What common themes emerge?
- What strategies/approaches have workers found helpful in dealing with people they have found difficult? Can you suggest ideas that might help each other?
- What training and/or support do workers need to perform this role with carers?

You might find it helpful in this context to draw up 'support grids' for yourselves – see Activity 2 (opposite.)

20–30 minutes

3 Creating action plans

Refer back to Module 1 for instructions and fill in your individual charts.

10–20 minutes

2 Support networks

Research suggests that support is critical in maintaining emotional health. It is most helpful if that support is fairly widespread, coming from a variety of sources.

You can use the chart below to look either at your own support network or at the support network of a carer you work with. Put ticks to show who can be turned to for help in each of the situations shown. For example, if you usually turn to your partner to discuss problems with the children, place a tick opposite this situation in the column headed 'partner'. There is space to add more situations and more sources of support. If a situation or a source of support is not applicable, cross it through.

Discuss in pairs, or in the group, how adequate you feel the network you have charted is. How could it be strengthened? What are the problems in trying to do so?

	Sources of support										
Situations	Partner	Parent	Son/ daughter	Brother/ sister	Friend A	Friend B	Boss	Priest	Prof worker	...	......
Financial problems											
Worries about work											
Depression											
Marital problems											
Feeling unwell											
Argument with superior											
Loneliness											
Problems with children											
Worries about future											
Difficulties with law											
...											
...											
...											
...											

(Adapted from English National Board (1987) *Managing Change in Nursing Education,* after Fransella and Bannister)

Managing your work

Criticisms of services

Carers do not find it easy to express negative feelings about hard pressed workers. They do, however, criticise the organisation and delivery of services. Three main areas of criticism are:

Access

- Lack of resources means that carers cannot always get access to services they need. For example, in Croydon the waiting list for the evening nursing service is so long that some people with long term needs cannot get care when they need it.
- Some workers, for example social workers and physiotherapists, can be difficult to get in touch with because they are often out of the office or have poor contact systems.
- Some procedures, such as those of the DHSS, are very difficult to understand.

Lack of ongoing contact

- There is no follow up after an initial assessment and carers are unclear if the involvement is over.
- Personnel changes due to shift work, reorganisation or staff turnover.

Unreliable service delivery Carers have busy and tightly scheduled lives and need reliable services. It is difficult when:

- no arrival time can be given, but workers just turn up, as district nurses tend to do
- workers do not arrive at the expected time because of other, unexpected priorities
- carers cannot get services at the time they would choose, for example getting up and putting to bed services.

When it works

Some professionals do manage their work so that carers' needs are met. This seems most likely to happen when:

- the carer's crucial role is recognised and carers are included in plans, as for example in occupational therapy assessments
- workers see themselves as invited guests and recognise the need to 'sell' themselves, as for example health visitors do
- workers do not have a substantial proportion of crisis work which results in unreliable arrival times
- the pressure of their caseload still allows time to be spent with carers.

Carers, understandably, appreciate a sensitive approach combined with an efficient service.

A carer's experience

A carer in Croydon who has had contact with the nursing service for several years as her husband's condition has got worse described her concerns about the reliability, timing and nature of the services provided. She spoke warmly of nearly all the nurses involved but had mixed feelings about the need for nursing support and the frequent interruptions to their home life. Her concerns included:

- The nursing service's inability to meet their need for an early, reliable service so that her husband is ready by 9.30 am to do two hours work with his secretary.
- The increasingly late arrival of the auxiliary nurse to complete her husband's showering, which often leaves her to do this.
- The unpredictable arrival time of the evening nurse (recently she was in bed at 10.40 trying to stay awake for the nurse).
- The number of nurses whom they meet, particularly since two nurses are now needed to lift him.
- The pressure on her to take on an increasing number of tasks such as giving her husband an enema.

Ways forward

Organising work and managing time in carers' interests may be helped by actions taken individually, at management or policy level, and at the interfaces between services.

At the individual level

It may help to:

- raise awareness of the needs of carers
- clarify with the carer the nature and extent of the service provided (for example to make it clear that if the auxiliary nurse is away then no bath will be possible that week)
- include a formal assessment of the carer's needs on a care plan, covering such things as:
  - what time would suit you?
  - when does it matter?
  - if we're late do you need to know?
- clarify those tasks the carer is willing as well as able to do
- manage workloads to meet carers needs as far as possible.

When the nature of the caseload means that carers' needs cannot be met, then the reasons for this should be identified and management support sought.

At management/policy level

- Resources should be allocated according to identified and prioritised need. (This could include assessing the weighting of caseloads in different areas.)
- Management statements should be made about the priority placed on reliability and continuity of services for carers.

At the interfaces between services

Arranging the services needed, such as respite care, can take a heavy toll of workers' time. It can be made worse by poor communication, for example between district nurses and social workers. Poor communication on discharges from hospital also creates problems of work and time management. Such difficulties need to be sorted out by individuals and/or their managers.

Group activities

Activity 1 (opposite) needs to be done *before* the session as preparation for Activity 2 'Time management discussion' and Activity 3 'Creating action plans' (overleaf).

20–30 minutes spread over a day

1 Time management check

The form opposite is designed to help you look at the way you organise your day. Its purpose is to help you check that your use of time is:

Effective in meeting the needs of patients/clients and those of their carers – you are able to do what they want, within the limitations of your role.

Efficient in meeting the needs of patients/clients and those of their carers – you can do this as quickly as possible, with the minimum of fuss, complication or intrusion.

Effective for the organisation you are part of – you are doing the right things, in the right way, for the right people, so that the organisation is achieving its goals, and your job is satisfying.

Efficient for the organisation you are part of – you are providing a set quality and quantity of service at the lowest possible level of resources.

It is important to recognise that there are often contradictions between these things. For example, it may be *efficient for the organisation* if you organise your rounds geographically, but this is *ineffective for the client* if she is got up too late to attend her day centre. Conversely, it may be *helpful to clients* if you are always available to answer the phone but *inefficient for the organisation* if the constant interruption means that letters don't get answered and case notes aren't properly written up.

The purpose of the form is to help you look at problems like these and identify how better management of your time could improve services for patients, clients, carers and the organisation you work for.

How to fill in the form Choose what looks like being a fairly typical day and pause for a couple of minutes every two hours to fill in the form.

Each line represents half an hour. Enter the time you start work on the first or second line and fill in the other times down the page.

The categories of activity you use will depend on your job, but might include:

- administration – phone, report writing, case notes
- meetings – formal and informal discussions with colleagues, consultations
- travel – (include time stuck in traffic)
- breaks – lunch, 'time for you'
- visits/interviews/assessments.

Analysing your form First, reflect on the activities you undertook and then put a tick, cross or n/a (not applicable) to show how efficient and effective you think each one was for clients, carers and the organisation you work for. Then consider:

- Did any one category (client, carer or organisation) stand out as a particular 'winner' or 'loser'?
- Is there a particular type of work where you should be aiming to improve efficiency or effectiveness?
- Where there are problems, what lies behind them?
- Can you choose an area of work where you would like to make an improvement? What can you do yourself? Who do you need to involve? What further resources might you need?

Time management check

Name

Date

Time	**What you did**	**Put a ✓ or a ✗ or n/a to show whether this was:** client effective / client efficient / carer effective / carer efficient / organisation effective / organisation efficient
Enter your times here 00		
30		
00		
30		
00		
30		
00		
30		
00		
30		
00		
30		
00		
30		
00		
30		
00		
30		

About 20 minutes

2 Time management discussion

Divide into small groups of 3–4 people from different jobs Share your experiences of keeping the time management check and look at each others' forms if you wish. Discuss:

- What differences are there between the various professions and organisations? Is it easier for some to organise their work with carers in mind? Why?
- What factors make it more likely that carers' needs will be taken into account? For instance, what part is played by:
  - the organisation of the service
  - the worker's degree of autonomy
  - pressure of work
  - professional assumptions about what the job entails
  - resources.
- What do you think is an acceptable level of efficiency and effectiveness to aim for in each aspect of the work you do? How far do you achieve it? Is the answer different for different workers? Are your answers as workers likely to be different from those given by carers, clients, colleagues or managers? Why?
- What do/should you do when you cannot organise your work so that it is efficient and effective for all three categories?

20–30 minutes

3 Creating action plans

Refer back to Module 1 for instructions and fill in your individual charts.

Collaboration

Gaps in the support net

Earlier Modules have described how carers criticise services for:

- difficulty in getting access to a service
- unreliable service delivery
- lack of information about what is available
- frequent changes of personnel.

Carers who have to deal with a number of services also complain that:

- they don't know who to contact for what
- necessary referrals aren't made
- services overlap
- the various workers involved don't know what the others are providing
- communication between workers is poor.

Better collaboration is often suggested as the way to overcome these criticisms, but what does this actually mean?

What is collaboration?

People in Croydon suggested the following ideas about what collaboration means:

- arranging case conferences
- making and accepting referrals
- consulting other workers about what you do
- understanding other workers' roles
- communicating about resources.

All these things may contribute to collaboration, but they may also do little more than enable each agency to be more efficient on its own terms. They may not change the service received by the carer. They may not make it more responsive and appropriate.

It can be helpful to think of collaboration as the end point of a progression which starts with working alone:

Working alone	Communication	Consultation	Coordination	Collaboration
'I'll do my thing'	'I'll let you know what I'm doing'	'I'll ask you before I do it'	'Let's fit together what we do'	'Let's examine what we each do and change it to meet the needs of the client'

Collaboration in Croydon

In Croydon collaboration has been made easier by recent (January 1987) organisational changes which have made Health and Social Service area boundaries co-terminous. Some examples of collaborative mechanisms that currently exist are:

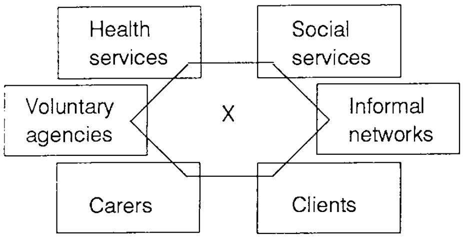
- a project set up to examine the overlap between the home help and nursing auxiliary services
- health liaison forums – fortnightly meetings of a range of professionals to discuss a case, consider alternatives and (usually) decide upon a care plan
- formal meetings between two senior managers from Health and Social Services to plan better services for people with mental handicap
- informal meetings of patch based workers.

At the moment there are no formal ways of collaborating to provide better support for carers.

In *The Limits of Altruism: Elderly Mentally Infirm People as a Test Case for Collaboration* (King's Fund, 1986), Dartington suggests that true collaboration is decidedly radical in its implications. He argues that it involves professionals in:

- working across agency boundaries
- examining and changing their attitudes to other professions and to their own role and responsibilities
- extending and blurring professional roles as they take on tasks not normally associated with their job
- negotiating an appropriate role for each worker involved
- examining and changing the ways they work together.

In this model, collaboration starts from a joint appraisal of the needs of the client or client group. It implies that more can be achieved collectively than separately. It opens the way for more innovative and appropriate solutions. It allows both carer and client to be involved as partners in the collaborative process. For example:



X = a 'temporary task system' drawing together all those involved.

'Temporary tasks' might be:

Client based, bringing workers together around a care plan for a particular individual.

Client group or problem based, for example planning the provision of services for people with mental handicap.

Patch based, responding to the needs of a local community.

Effective collaboration at grass roots level requires collaboration throughout each of the services concerned. If the structures, mechanisms and forums don't exist at senior and middle management level, it is difficult for individual workers to achieve anything more than better consultation and coordination.

Problems in collaboration

Greater collaboration has clear benefits. But there are problems and constraints which make it hard to achieve.

Lack of management support may restrict what workers can do. Collaborative practices may also weaken managerial control and require a review of systems of accountability. Some managers may find this threatening or unacceptable.

Professional rigidities Boundaries exist to maintain differences between agencies and professions. Workers in different disciplines have differing attitudes and behaviours towards clients. Mutual understanding of these can lead to a better service; but they can also be a cause of conflict, rivalry and mutual blame.

Difficulties of replication Collaborative practices often come about because of personal factors as much as changes in roles or structures. They may need to be negotiated afresh with each change of personnel. What works in one place may not be appropriate in another. The reliance on personal contact can also mean that an individual opposed to collaborative work can block it.

Group activities

Choose any or all of activities 1–3 before looking at action plans.

About 1 hour

1 Critical incidents

Divide into pairs Take a few moments to think about incidents in your own work that have showed:

- good collaboration
- bad collaboration
- a lack of collaboration.

Take it in turns to describe an incident, saying when it started, what happened, who was involved and when it ended. Describe specific incidents rather than making general points. Discuss each incident looking carefully at:

- What caused the incident to develop as it did?
- Who could have influenced what happened?
- What does each incident reveal about the possibilities and difficulties of collaboration?

Continue to relate and discuss incidents until you start to get a feel for what helps and hinders collaboration in your own work. Allow about 20 minutes for this.

In the group, share your ideas about the factors that help and hinder collaboration. (Do not recount the critical incidents again or you will run out of time.) You may find it helpful to group them as:

Individual qualities and abilities (for example, on the one hand flexibility, an interest in innovation, skills in relating in groups; on the other hand a quest for power and control, rigidity or defensiveness).

Strengths and problems associated with individual professions (for example the time constraints of one group, ethical assumptions of another, level of responsibility of a third).

Strengths and problems associated with middle and senior management (for example organisational relationships, willingness or refusal to collaborate at this level, relationships between individual senior managers, policy decisions that determine particular ways of working).

20–30 minutes

2 Role restrictions

In pairs take it in turns to be talker and listener.

Talker Think of a case you know which involves a carer and describe it briefly. Then complete the sentence below with something you might do for this carer or client but don't because you feel it lies outside your role or professional responsibilities:

'If I wasn't a (district nurse/home help/GP etc) I might ...'

For example: 'If I wasn't the home care organiser I might have helped her give her mother a bath.' 'If I wasn't a physio I might have taken up her housing problem'.

Listener Encourage the talker to complete the sentence with at least five different endings, more if they can.

In the group discuss:

- What do your examples tell you about the limitations of your roles?
- What stops you stepping out of role? Is it, for example, fear of treading on someone else's toes? The feeling someone else *ought* to be doing it? Lack of time and resources? Fear of losing your professional role and status?
- What situations are helped by workers stepping out of role?
- What needs to change:
  - in organisational relationships
  - in systems of care
  - in individual attitudes

to make role changes possible?

30–40 minutes

3 Collaboration snapshots

This activity asks the group to take two 'snapshot' views of its working relationships – one as they are at present and one as they need to be if people are to work together more effectively to support carers. This is done by moving physically to show these relationships.

Some groups find it easiest to do the snapshots in silence. Others like to talk about what they are doing and negotiate as they go along. Either way is valid. Occasionally people find the idea of the activity threatening or odd. Try to overcome these feelings if you can as the results are often striking and more illuminating than any amount of discussion.

First think for a moment about your working relationships with other people in the group. Stand up and move so that you are in a position that expresses that relationship at present. Stand close or at a distance, facing or with your back to someone, seated at their feet or standing over them. Adopt whatever position expresses something for you about the way you relate at present.

Then think about how you need to relate if you are to work together more effectively to support carers. Move again to show these relationships.

It is important to allow time for each snapshot to settle and for people to take it in before moving on to the next stage of the activity.

At the end of each snapshot, the facilitator should describe what he or she observed and group members should discuss why they placed themselves as they did. Think about:

- How do you feel about the way others placed themselves in relation to you?
- Who got left out? Who was central?
- Where did the carer figure? Where was the GP?

After you have discussed both snapshots, consider what actions need to be taken to move the group from the relationships in snapshot 1 to those in snapshot 2.

20–30 minutes

4 Creating action plans

Refer back to Module 1 for instructions and fill in your individual charts.

Packages of care

Better tailored services

Carers need varied, flexible, reliable services which are coordinated to meet their individual and changing needs – a 'package of care'. This can be achieved by:

- better use of care plans
- use of problem oriented records
- better communication systems
- greater emphasis on the carer and client as individual consumers of services
- a key worker scheme
- a package of support scheme.

Whatever package of care is eventually created, it is important that it:

- takes account of both the carer and the person cared for
- is flexible and can take account of changing needs
- includes a clear reference point so the carer can relate to one person across the agencies involved.

A key worker scheme and a 'package of support' scheme are described below as examples of this.

Key worker scheme

A key worker may be nominated from either health, social or voluntary services. Their possible tasks may include:

- analysing needs and identifying gaps in provision
- mobilising and coordinating the various services as required
- ensuring good communication between the different agencies
- ensuring that assessments and reviews of changes in a carer's needs are carried out.

A key worker takes an overall view of individual needs, attempts to ensure that defined needs are met and acts as a case coordinator.

The key worker role may be filled by a designated person, or be the responsibility of a team.

People in Croydon were enthusiastic about a key worker scheme but raised a number of questions that are likely to be echoed elsewhere:

- Which cases need a key worker appointment?
- At what stage and how should a key worker be appointed?
- Who should be the key worker – the first person involved, the person most frequently in contact and/or providing the most support? (People from both social services and the health authority were concerned that their workers might be expected to pick up the key worker role too often.)
- Who is the key worker accountable to, for what?
- How would agency and professional boundaries be overcome?
- Would the job of a key worker continue as long as the caring? Could key workers change as the caring situation altered?
- Do key workers have an advocacy role?
- Can the carer/cared for person complain about the key worker? If so, to whom?
- How do you ensure the key worker has the necessary skills and a knowledge of other services/agencies?
- How would cases be reviewed?

A 'package of support' scheme

This approach has been used to provide flexible packages of home support to elderly people suffering from senile dementia, and their carers, so as to avoid or postpone admission to institutional care.

A package of support to suit individual needs is provided within a specially allocated budget, for example the equivalent cost of a hospital bed or residential care. The case coordinator, who has budgetary control, buys in resources as needed and is responsible for ensuring cooperation between the service providers. Gaps in statutory services provision (such as a sitting service or putting-to-bed service) can be purchased from the private sector or appropriate members of informal networks.

Like the key worker scheme, this model needs the support of all agencies. It also needs agreement on financing.

Group activities

About 45 minutes

1 Choosing a model of care

Individually, read through the case study opposite.

In the group, imagine that you are involved in this case and together enact a case conference to decide how to provide an appropriate package of care. The case conference may need to discuss:

- the needs of Mr Brown and Mrs Green and any conflict between their needs
- what help is available
- how each worker can fit what they have to offer to Mr Brown's and Mrs Green's needs
- what different options can be presented for Mr Brown and Mrs Green to choose from
- a possible care plan
- who will do what
- how to coordinate care
- how to maintain contact and relationships between the different services.

If it is unlikely that you would be involved in this case, act as an observer. Position yourself outside the group and watch for things such as:

- How well do the group establish the needs of Mr Brown and Mrs Green?
- How do they negotiate what should happen?
- How extensive is the collaboration?
- What problems might arise in the future?

Alternatively, one person can take the role of Mrs Green at the case conference. This turns the activity into a role play and the person taking this role will need time to brief and debrief herself. Do not attempt this unless you are familiar with role play.

Finally discuss in the group:

- people's preferences for different ways of providing care
- how people's roles and relationships would need to develop to provide flexible, individually tailored packages of care
- changes that might be needed at senior management and policy level.

Mr Brown – a case study

Mr Brown is eighty years old. For the past five years he has lived in a one bedroomed flat with his divorced daughter, Mrs Green. Mrs Green sleeps on a camp bed in the living room. Until now she has not requested any form of help with the care of her father.

Over the past few months Mr Brown's behaviour has become problematic. He has taken to walking around the flat at night shouting, and turning on taps in the bathroom. He is often confused and appears to be suffering from loss of memory. The neighbours have complained to Mrs Green and to the landlord of the block in which they live.

Mrs Green has found it increasingly difficult to cope with her part time job, the demands of her father and the pressure from the neighbours. She has told one neighbour that she wishes her father would 'just get on and die' though on other occasions she says 'He's my dad, he's all I've got.'

Mrs Green has begun to lose weight. She has become short tempered with her father and, at times, hit him. When she goes out to work she locks him in the bedroom to prevent him damaging anything.

After a particularly violent confrontation with her father, Mrs Green locked him in the bedroom and went to the local Social Services Department offices. She demanded that they 'do something'.

Mr Brown has no wish to be admitted to a home for the elderly and Mrs Green might be prepared to continue to care for him under different circumstances.

20–30 minutes

2 Creating action plans

Refer back to Module 1 for instructions and fill in your individual charts.

Communication

The need for good communication

Sometimes an extensive range of agencies and workers are involved in supporting carers and those they care for. The help one family received when their daughter was born with spina bifida and hydrocephalus is shown on the charts overleaf.

Chart 1 shows the frequency of contact from 15 different individuals and agencies over a period of nearly four years.

Chart 2 shows the way in which each individual and agency was brought into the case.

The family feels that both the timing and the nature of the support have been mainly positive. This reflects the good communication between all those concerned.

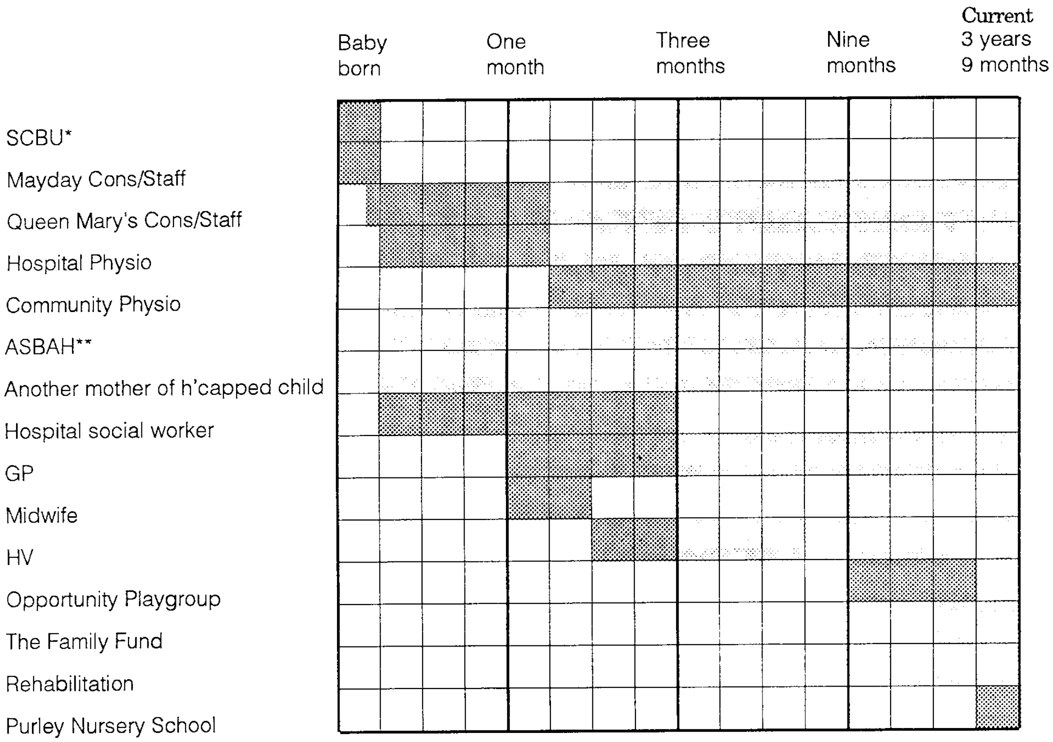
Barriers to communication

Anyone who has worked on a case involving a large number of other workers knows that maintaining good communication like this can be difficult. Listed below are some of the possible barriers to communication:

- different boundaries for different services, leading to confusion about who to deal with
- differences in hierarchy and in status of people who need to deal with each other
- a history and culture of dislike, criticism and bad communication between organisations
- frequent changes of personnel
- lack of established forums where people from different jobs can meet
- lack of personal contact with people from other services
- lack of understanding of the importance of good communication
- poor record keeping systems
- lack of administrative back-up to facilitate good communication and exchange of information
- poor telephone contact systems which make it hard to leave messages or get replies to queries
- reluctance to share information for reasons of confidentiality
- different trainings and backgrounds leading to different assumptions about what constitutes good or appropriate care
- ignorance of other services and what people do
- isolationism – the tendency to work without reference to others
- prejudiced dislike of another organisation's approach
- use of jargon
- pulling rank or professionalism to justify an argument or decision ('As the … I think I have the right to say what's best in this case.')
- organisational arrogance ('We can deal with this one.').

In many cases such barriers are overcome through changes in attitude and the introduction of appropriate systems. In the case charted overleaf, for example, the community physiotherapist worked as an unofficial key worker, often mediating the family's contact with many of the other workers involved.

Chart 1
Time analysis of support for one family with a handicapped child



	Baby born				One month				Three months				Nine months		Current 3 years 9 months	
SCBU*	▨															
Mayday Cons/Staff	▨															
Queen Mary's Cons/Staff		▨	▨	▨	▨											
Hospital Physio		▨	▨	▨	▨											
Community Physio						▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
ASBAH**																
Another mother of h'capped child																
Hospital social worker		▨	▨	▨	▨	▨	▨	▨								
GP					▨	▨	▨	▨								
Midwife					▨	▨										
HV							▨	▨								
Opportunity Playgroup													▨	▨	▨	
The Family Fund																
Rehabilitation																
Purley Nursery School																▨

▨ Frequent contact – at least fortnightly

☐ less frequent contact

*SCBU = Special Care Baby Unit

**ASBAH = Association for Spina Bifida and Hydrocephalus

Chart 2

Initiators \ **Brought in**	SCBU	Mayday Cons/Staff	Queen Mary's Cons/Staff	Hospital Physio	Community Physio	ASBAH	Another mother of h'capped child	Hospital social worker	GP	Midwife	HV	Opportunity Playgroup	The Family Fund	Rehabilitation	Purley Nursery School
SCBU															
Mayday Cons/Staff			✗						✗						
Queen Mary's Cons/Staff				✗	✗			✗	✗						
Hospital Physio						✗	✗	✗							
Community Physio												✗			
ASBAH															
Another mother of h'capped child															
Hospital social worker															
GP										✗	✗				
Midwife											✗				
HV												✗			
Opportunity Playgroup															
The Family Fund															
Rehabilitation															
Purley Nursery School															

✗ Shows who was brought in/directly referred to by which initiator

Group activities

Do either or both of Activities 1 and 2 before looking at action plans.

About 20 minutes

1 Types of contact

Individually imagine you were one of the workers involved in the case shown overleaf. In order to work effectively with the family, what type of contact would you have needed with the other workers and how often would you have wanted it? Think about:

- meetings to find out what other workers do
- case conferences
- letters
- phone calls
- meetings with the family
- ways of overcoming barriers to good communication.

In the group share what you think it would have been necessary to do and discuss any difference of opinion.

About 30 minutes

2 Communication maps

If you are to support carers effectively, which other workers do you need to have links with?

Individually:

- Write your name in the middle of an A4 sheet of paper.
- Round the edge write the names of the workers you may need contact with. If you cannot write a name, write a role (for example GP, OT, DHSS, housing worker).
- Draw in the links between you and these people:

———— links that exist and are effective
— — — — links that don't exist or need developing.

- Think about the kinds of links you want to develop with each person and how you might use them.

In the group find a partner and talk with each other for one minute about the connection between you. Is it satisfactory? Not necessary? Does it need developing? What could you do to improve it? After one minute move on to another partner and do the same again. Repeat the exercise until everyone has spent one minute with everyone else. It will help if one person takes responsibility for calling time when each minute is up.

When everyone has spoken to everyone else, share how you felt about the activity – and what you might do as a result. Finally, discuss how you might develop better links with people on your maps who are not present. This discussion should give a good basis for your action plans.

20–30 minutes

4 Creating action plans

Refer back to Module 1 for instructions and fill in your individual charts.

Information

Information for carers

Information is often the first vital step in carers getting the support they need. With their limited energy and resources, carers need information that is easy to obtain and easy to understand. Just another phone number is not always helpful.

Written information

Written information needs to be in plain English, with translations into other languages where necessary. Information packs may be useful. They could include:

- information on the common experiences of carers and the most common resources
- information on a specific condition
- available local and community links.

Such packs need to be available in places that carers visit frequently, such as doctors' surgeries, post offices, day centres. They need to be written from the carer's perspective, consumer tested and updated frequently.

Spoken information

Carers receive a lot of information orally from workers. The *timing* of such information is important. Any information needs to be given as early and as fully as possible, and to be repeated and updated frequently to take account of changes.

When giving information it is important to be sensitive to the feelings of the carer, to allow time for questions and to arrange for return visits to clear up things that may not have been understood.

Information giving by professionals has improved over the years, but attitudes and standards are still variable. A parent in Croydon commented on the lack of sensitivity she met when she was told that her baby had spina bifida:

'I feel that it was rather unfair of the consultant to paint such a bleak picture of our daughter's condition as neither he nor we knew, clearly, at that time, exactly how she would be in future years. I believe it might be useful for doctors to have a course of psychology training when learning to break news of this kind to patients.'

Information for workers

People working with carers also need information in order to manage and provide services effectively. They may need:

- background information on carers' general needs
- medical information on the condition or prognosis of the person being cared for
- knowledge of the existing support involved, including the contribution and limitations of the carer
- knowledge of resources available, including the criteria for access and limits of those resources.

Concerns about existing information resources

One of the Practice Development Groups in Croydon identified the following concerns about existing information resources.

The existing support provided is unclear Even within one organisation people can be unclear as to who is involved and in what way. Between organisations the existing pattern of support can be equally unknown. The existing informal support may also be unclear.

The range of available information is unknown The plethora of organisations and networks which could be relevant to carers makes it highly unlikely that any one person will know them all. There are, for example, 200 groups that deal specifically with physical handicaps.

The resources available constantly change Information on groups and services needs frequent updating. In Croydon there is currently (1987) no person responsible for this. Clear and detailed information is needed if the most appropriate resource is to be identified.

Information is known by one person Individuals build up personal knowledge of available resources and contacts. When they leave this resource is lost.

The GP's role Both carers and those working with them may see the GP as the most appropriate source of information. GPs may be unable or unwilling to perform this role and can be slow to refer, unaware of the existence of the range of services available.

Tackling problems such as these requires greater information sharing and collaboration amongst workers.

Group activities

Do either or both of Activities 1 and 2 before looking at action plans.

20–30 minutes

1 Case study discussion

Here are four different situations in which carers are involved:

a) A 65 year old widow cares alone for her 40 year old unemployed son who has schizophrenia. She is about to go into hospital for a hip replacement operation.
b) A couple in their mid-forties have a teenage son who is about to be discharged from a spinal injuries unit following a motor cycle accident. The son is in a wheelchair and is unlikely to walk again.
c) A couple in their mid-twenties have a 6 week old baby (their first child) with Down's syndrome.
d) An 83 year old man cares for his 82 year old wife who has Alzheimer's disease.

Individually, think about the case you would most likely be involved in.

- What information would the worker, the carer and the person cared for need?
- How would they each get it?
- What difficulties would they face?
- What would you need to be particularly sensitive to if you were offering information?

In the group share your ideas about the information needed and how it should be obtained and offered.

20–30 minutes

2 Sharing information

In pairs discuss your needs for information when working with carers, and any difficulties you have in obtaining information Then each list:

a) all the information sources you have access to that are helpful in your work with carers. Include other people as well as written material and organisations.
b) any gaps in the information directly available to you. What would you like to know about but don't know how to find out?

In the group go round so that each person gives from their (b) list one problem they have in obtaining information or a gap in the information they have. List these on a flipchart. Carry on until all problems and gaps are listed. Then take each one in turn and check out from people's (a) lists who has information that might help. Write names against the items on the list so that people can contact each other later to discuss them.

Finally in the group discuss how you could:

- develop better borough/district wide information resources for workers
- develop better access for carers to information
- improve access to each other's sources of information
- solve any ethical dilemmas in sharing information.

20–30 minutes

3 Creating action plans

Refer back to Module 1 for instructions and fill in your individual charts.

Statutory/voluntary sector relationships

What is the voluntary sector?

The 'voluntary sector' is a large, diffuse, not easily defined collection of organisations and individuals. At one end of the spectrum are the paid workers from well established charities with experienced management committees and secure finances. At the other are self-help groups which rise and fall as their membership changes.

Some voluntary organisations consist only of volunteers, some have paid workers, some receive funding from central and local government, some receive charitable funding, and some are financially self-sufficient. For some workers, volunteering is a full time and permanent commitment. For others it is an occasional couple of hours a week. Voluntary organisations also differ in their organisational structures, formality and political outlook. Some provide services, some are pressure groups, some are self-help groups. The variations are endless.

Diversity is one of the strengths of the voluntary sector. When a need is identified a voluntary organisation can arise quite quickly to meet it or press for it to be met. But diversity is also a problem. Workers in the statutory sector find it hard to keep abreast of what is on offer, quality varies, and ignorance can lead to suspicion on both sides.

Voluntary sector support for carers

Many established voluntary organisations already support carers, mainly through information and services offered to those cared for. In the absence of a recognised policy to support carers, and with limited and patchy provision by the statutory sector, the role of the voluntary sector is open for debate. Some possible contributions include:

- offering a service and a relationship that does not involve the carer taking on client status
- filling gaps in existing provision
- developing new initiatives which provide models of good practice
- contributing to joint planning
- raising awareness of carers' needs
- acting as pressure groups
- providing mutual support.

Running through many of these possibilities are questions about what the best role(s) should be. Is filling gaps, for example, letting the statutory services off the hook or providing services on the cheap? What about the conflict between providing a service and acting as a pressure group?

Problems in statutory/voluntary relationships

Croydon has a history of commitment to voluntary work with a jointly funded Department of Community and Voluntary Services which employs a number of volunteer organisers. A wide range of voluntary organisations provide services for carers. The voluntary sector is represented on the Joint Consultative Committee and at Joint Chief Officers Group meetings.

Despite these positive factors, workers in Croydon identified many difficulties which are typical of statutory/voluntary relationships:

- statutory workers are unaware of what is available in the voluntary sector
- the voluntary sector and volunteers in particular are not always used
- statutory workers define problems, take decisions and expect volunteers to go along with this
- there may be differences of attitudes and approach between the statutory and voluntary sectors
- some statutory workers see volunteers as unreliable
- issues of confidentiality can make it hard for statutory workers to involve volunteers fully
- there is a lack of clear criteria in deciding which voluntary organisations receive funding
- the need to obtain funding may lead to voluntary organisations gearing applications to funding bodies' expectations rather than clients' needs.

From the voluntary perspective, statutory services may at times seem bureaucratic, indifferent, inefficient, controlling, patronising, with unreasonable resource constraints.

Workers in Croydon had a number of clear ideas of actions that might improve relationships:

- better liaison and communication
- training for volunteers to enable them to take on tasks for carers
- multi-disciplinary training to reduce barriers
- education for managers about volunteers
- accurate information on voluntary
- linking groups of volunteers with social services area teams.

Group activities

About 30 minutes

1 Case study discussion

Individually read through the case study below.

A group for carers of people with dementia was recently set up in Croydon by workers from health, social services and the voluntary sector. It involves community psychiatric nurses, day care workers from social services, a voluntary organiser from CVS, workers from a community centre and volunteers. Listed below are some of the issues they had to resolve and some of the tensions they experienced in working together.

Issues:
- Who owned the group? Statutory workers assumed they would run it, calling on the voluntary sector for support. This was challenged by community centre workers, who emphasised integration into the community and multi-disciplinary work.
- How should the group be resourced? The community centre had the necessary rooms, facilities and transport but there were different views on their allocation and management.
- Should the group be open or closed? What were its aims? What role would each worker take?
- How should supervision and support be provided? Collectively or at workers' own base?
- Who would the volunteers work with? Just the cared for or the carers as well?
- How would the confidentiality issue be handled?

Tensions:
- Community centre workers felt devalued by statutory workers' assumptions 'They think we've got nothing to offer except the building.'
- There were doubts as to whether workers were involved out of genuine interest or because of management policies about collaboration.
- Perceptions differed of the time taken to set up the group: 'It's taking ages' versus 'It's important to ground it in the community'.
- Prior relationships and previous experiences of working across agency boundaries influenced how people felt about the project.
- Different approaches, skills and knowledge needed to be integrated.

In the group, discuss:

- What are the advantages of collaboration of this kind? What is the unique contribution of each sector that is likely to make a collaborative venture more successful than one provided by one service alone?
- What is similar and what is different in the approaches of workers from health, social services and the voluntary sector? What values lie behind the differences? How are they likely to affect collaborative work of this kind?
- How would you anticipate and resolve the issues and tensions listed in the case study? Think about:
  - a) what kinds of things need to be talked about, when and by whom
  - b) ways in which problems arising from different values and attitudes – which seem obvious in retrospect – can be anticipated.
  - c) mechanisms such as planning meetings and joint supervisions that can be used to work out problems of this kind

If you want to bring the discussion closer to home, you might like to consider whether you could set up a similar project in your local area.

- What would be the advantages for workers, carers and the people cared for?
- What would be the difficulties?
- How could you anticipate and overcome the problems in this type of collaboration?

20–30 minutes

2 Creating action plans

Refer back to Module 1 for instructions and fill in your individual charts.

Informal networks and neighbourhood care

Community care – myth or reality?

Policies of community care emphasise a shift from the provision of services in institutions to the provision of services in the community. Recently the emphasis has also shifted from statutory provision of services to the roles and responsibilities of family members and concerned others as the primary providers of community care.

The family and other informal settings are seen as the main source of care for all dependent people. However, there are few instances of informal networks providing substantial support for heavily dependent people. Once one person, usually a *female relative*, has become the main carer, other relatives withdraw support, leaving this person to cope alone.

Friends rarely provide any regular practical help. This may be because carers see friends as an inappropriate source of practical support, or find offering help in return a problem. Friends may be anxious that offers of help could lead to demands which they feel unable or unwilling to meet. They may worry about their ability to cope with medical, nursing or behaviour problems. Finally, the isolation of carers makes it difficult for them to sustain friendships.

Neighbours can provide social contacts which reduce carers' isolation. However the practical help they give is usually restricted to impersonal, light or pleasant tasks such as shopping, cooking or gardening. It is more likely to be offered to help the very young and the very old, ages when people normally need help.

Help from neighbours, as from the statutory services, is often gender related: male carers are seen to need more practical support than female carers. As with friends, the inability to offer help in return can be difficult for carers.

The traditional image of neighbourhoods – people in close relationships sharing common values and interests and identifying with the place in which they have lived for a long time – needs to be examined critically. The reality of family relationships, friendship and neighbourhood ties is often very different. By itself it is unlikely to provide carers with what they need. This raises questions about the rights and responsibilities workers have in developing and promoting informal networks of community care.

Neighbourhood care schemes

Good neighbour schemes attempt to develop patterns of social care which emphasise informality, reciprocity and locality. They can be seen as a substitute for informal networks, blurring the boundaries between formal and informal care.

Schemes are usually organised by the voluntary sector, mobilising volunteers to keep an eye on vulnerable people in the neighbourhood and to provide a range of help and support. Training and monitoring of volunteers is usually built into the scheme. In Abrams' study (Abrams, P et al (1986) *Creating care in the neighbourhood*, Advance), people saw visiting as the most appropriate function for such schemes, and preferred paid help to provide services for long term care. Paid help and informal care were not seen as mutually exclusive, however, and a wider range of services might be acceptable to both helpers and helped if payment were involved.

In Croydon, Good Neighbour Schemes have been running since 1977. The most flourishing are linked into day or community centres and include a paid coordinator. Difficulties arise from the unstable membership of both helpers and helped. This can lead to problems in establishing and sustaining the value and reliability of the scheme in the eyes of statutory agencies and prospective users. The schemes reflect dominant social divisions in that they include few men and few members of ethnic groups and flourish best in areas where they link into an existing social network.

Policy implications

Volunteers can clearly provide effective services and valued contact in some areas, but payment plays a necessary part. This may be one way of making the 'caring pool' found among neighbours more acceptable and available to carers, who currently find such limited support among their family and social networks.

Group activities

Do Activity 1, and if you wish Activity 2, as a basis for discussing action plans related to informal networks and neighbourhood care.

20–30 minutes

1 Reviewing your patch

Divide into groups each focused on a small geographical patch and consider the following questions:

- What neighbourhood care schemes exist or have existed in this patch?
- What support do carers in this patch get from informal networks of friends and neighbours?
- What are the social and economic characteristics of the patch? Think about:
  - social class and prosperity
  - ethnic mix
  - age breakdown: lots of families? young, single, mobile? elderly?
  - type of housing: owner occupied, private or local authority rented? well-maintained? run-down?
  - stability of the population
  - economic base/sources of work
  - community facilities: shops, transport, schools, community centres, meeting places, leisure and sports facilities
  - existing organised networks: clubs, societies, charities, voluntary organisations, churches.
- What do your answers to these questions tell you about the strength of informal networks and the likelihood of neighbourhood care schemes succeeding?

If this discussion highlights gaps in your knowledge of your patch, you may want to plan how to find out more and hold a follow up discussion of the issues involved.

About 15 minutes

2 A particular case

You may find it helpful to focus your discussion by thinking about a particular case. Imagine this family lived in your patch:

John Black is a 17 year old with a history of anorexia and problem behaviours concerned with diet. His failure to learn basic living skills has been ascribed both to psychosis and to mental handicap. In the absence of any other facility, he is attending a day centre for mentally handicapped people. He lives with his parents who are in their mid-forties.

Mr Black works full time as a post office engineer. Mrs Black has had a variety of temporary and part time jobs which she gives up whenever John needs full time care. She would like to retrain in modern office work techniques and return to full time work. She wants John to continue to live at home but is often depressed at the thought of the continuing responsibility and the restriction on her ambitions.

Recently, John has slowed down to the extent that Mr and Mrs Black have to do almost everything for him, including taking him to the toilet. He has continued to lose weight and has taken to stealing and hiding food. The neighbours have complained that John has been knocking at their doors asking for food and cigarettes. When they ask him to leave he behaves as if he hasn't heard them or walks very slowly around their gardens.

- What would be the likely public reaction to John if he lived in your patch? Sympathy? Understanding? Annoyance? Incomprehension?
- What forms of help might John and his family want from friends and neighbours?
- If you think informal support is possible, how could this be coordinated with formal provision and incorporated into a multi-disciplinary approach?
- If there is no possibility of help from an informal network, or neighbourhood care scheme, how can statutory services support this family?

20–30 minutes

3 Creating action plans

Refer back to Module 1 for instructions and fill in your individual charts.

Implementing change

Factors involved in change

Many of the ideas you have been collecting in the previous Modules will – if you put them into practice – involve you and the organisation you work for in some kind of change. In order to decide which ideas to implement, you first need to assess how easy each change would be to carry through.

There are three things to consider:

1 The idea or change you are proposing.
2 The environment you are introducing the change into.
3 Yourselves as 'agents of change'.

1 The idea or change you are proposing

Your idea is most likely to succeed if:

☐ other people in the organisation(s) concerned see it as relevant and appropriate
☐ it doesn't threaten the organisation's existing values
☐ it meets the needs of people in the organisation
☐ the potential gain is greater than the potential loss
☐ it is easy to understand
☐ it can be put into practice easily and with little disruption
☐ the organisation has the resources and the skills to make the change
☐ it is possible to try out the change without making a full scale commitment to it (by piloting for example)
☐ the effects of the change are easy to observe.

If you find that your idea meets few of these criteria you can either:

- decide on further preparation to make the idea more acceptable
- alter the idea to make it more acceptable
- reject the idea as probably unworkable.

What you choose to do will depend on the environment into which you are introducing change.

2 The environment

'Environment' covers all aspects of your organisation. It includes such things as:

Personal factors like the feelings, ideas and attitudes of the people working for the organisation, the stress they are under, the degree of conflict or cooperation amongst people, their workloads, confidence, influence and power.

Internal organisational factors like the way the organisation is structured, management relationships, availability of resources and training, power structures, politics and ideologies.

External organisational factors like the pressure from funding bodies and controlling committees, relationships with other organisations.

An organisation is likely to respond well to new ideas when:

☐ organisation structures make innovation easy – for example, decision making hierarchies are responsive, there are communication channels and decision making structures at appropriate levels within and between organisations, the organisation is free of restricting rules and procedures
☐ people in leadership positions are supportive (or likely to be supportive) and put their influence behind innovation
☐ there is good contact and communication between colleagues at the same level and up and down hierarchies and chains of command
☐ people can feel that they own the new ideas and be involved in formulating and implementing them – they come from a groundswell of need for change
☐ people who are opinion leaders give their backing to the ideas.

In many situations where change is needed, work needs to be done to prepare the environment first. This may involve informal discussions with key people, testing out ideas, making alliances and finding out whose support is needed and obtaining it. It may mean consulting with clients, carers and colleagues about whether or not the idea is appropriate. It may mean introducing ideas in a way that allows other people to influence and own them, modify and develop them. It may mean confronting and working through objections and resistance, taking time to deal with them. Sometimes it can be helpful to bring in an outside consultant to assess the situation and advise on change strategies.

Creating the climate for change in this way can be time consuming and frustrating, but it is a surer basis for success than banging your head against a closed door or imposing something on unwilling subordinates. How far you as an individual can do this will depend partly on your position and power within the organisation, but also on your ability to act as an 'agent of change'.

3 The agents of change

Experience suggests that successful 'change agents' are dynamic, forceful individuals who can combine strength and credibility with sensitivity to the needs of others. They tend to be self-aware, self-critical people who can take account of other people's views without being deflected from their main purpose, able to convince others and inspire confidence in their ability to carry change through.

These attributes can sound daunting. However, if you are introducing a simple idea that is likely to be readily acceptable you will not need all these superperson qualities. The idea will probably stand on its own. If on the other hand you are introducing a difficult idea into an unwilling environment then these qualities are important. If you don't feel you possess them, then identifying people who will take up the idea or work with you is the key factor. The change agent can be more than one person.

It is important for each individual to develop a plan for action that they feel happy with and is likely to succeed. There is no point in burning yourself out on a project that is unworkable or trying to go it alone in the face of impossible odds. On some things you may wish to work alone, some you may wish to pass on to others to deal with, some may be best worked on collectively and on some you may wish to take a leading role. The activity which follows provides a structure for deciding what you will do, taking into account people's interest in the ideas proposed as well as ease of change.

1½–2 hours

Group activity — Action plans

In this activity you are asked individually and collectively to develop plans for change, working on the basis of the ideas you have developed while discussing previous Modules.

Charts 1 and 2

Individually

Read through Chart 1 'Individual actions now' and Chart 2 'Actions for colleagues or line managers' (in Module 1) which should now be complete.

In column 2 of the charts 'degree of interest' give each idea a score from 0 to 5 to show how interested you now feel in it:
5 = can't wait to get started
4 = very interesting
3 = interesting
2 = not very interesting
1 = of little interest
0 = no interest at all

Take each idea in turn and scan again the factors affecting change described overleaf (the idea itself, the environment and yourself as an agent of change.) Then in column 3 of the charts 'ease of change' use a score from 0 to 5 to show how possible you think it would be to introduce that change:
5 = no problem at all
4 = very easy
3 = easy
2 = difficult
1 = very difficult
0 = just about impossible

You are now in a position to consider what you will do. If you are lucky you will have some ideas which show high scores in both columns indicating that you are very interested in them and that they are likely to be easy to achieve. It is also probable that there are ideas you are very interested in that are likely to be difficult to achieve.

In pairs:

Discuss the ideas you are most interested in, looking at what you might do to achieve them, the difficulties involved and how you might overcome them.

Each of you pick *two ideas from each chart* that you would like to achieve. In making your choice you should be weighing up the ease of the task you have chosen and your interest in it.

With the help of your partner write an outline plan for each of your chosen ideas under the headings objectives, actions and target dates as in the example opposite. The fourth column 'Achievement' can be filled in with comments on your progress as you work on the plan.

In the group:

Share what you have decided to do.

Example

Objective	Actions	Target date	Achievement
Monitor my attitudes and behaviour with carers	1 Keep a diary for two weeks of visits that involve a carer, noting time spent talking to carer, what discussed, my response to requests etc 2 Discuss my diary with a colleague.	Two weeks from now	
Setting up a support group for carers	1 Read accounts of other support groups. 2 Discuss idea with line manager. 3 Discuss idea with colleagues. 4 Contact carers for their views/ideas. 5 Investigate suitable venues.	Three months from now	

Chart 3

In the group:
On a flipchart or blackboard mark up four columns headed:

1 Ideas	2 Importance	3 People	4 Ease of change

Ask each person in the group for one idea they have noted on their own copy of Chart 3 about actions the group itself could take to improve support for carers, and write these in column 1. Carry on until all ideas are entered. It may be helpful at this stage to allow brief explanation and discussion of ideas and to combine ideas that are broadly similar. Do not go into detailed discussion at this stage or you will run out of time.

Each person now has ten votes which they can use to show how important they feel it is that the group pursues the issues written up. At one extreme you could give all your ten votes to one idea. At the other you may give just one vote to each of ten ideas. Enter these votes in column 2 'Importance'. Adding up these votes will give you an idea of the strength of feeling in the group; but it does not tell you who is prepared to carry the idea forward nor how possible people feel the change to be. Look at this next.

Start with the idea that received most votes and in column 3 write the names of all the people prepared to do something *active* about it. If no one volunteers then the idea is a non-starter and should be abandoned. Next agree a broad change rating on the scale of 0 (impossible) to 5 (no problem), just as you did for Charts 1 and 2. If there is disagreement on how difficult an idea will be to implement, take more notice of the views of those who are offering to do something about it.

Carry on until each idea has names and a change rating written against it. Your completed chart should look something like this:

Example

1 Ideas for change	2 Importance (votes)	3 People	4 Ease of change (group rating)
Produce a carers' information pack	2,8,7,5,2,1,5 Total: 30	Sam, Jill, Tom	2
Prepare a report for senior management on the need for a key worker system	4,6,6,1,1,1,1 Total: 20	Charles, Jane, Liz	4
Coordinate more quickly with other agencies	4,2,3,1,2,4,4 Total: 20	William, Sam, Jill, Charles, Jane, Liz	3
etc			

Example

Objective	Actions	Target date	People involved	Achievements
Produce a carers' information pack	1 Obtain other information packs – Sam 2 Set up a planning meeting for those involved – Jill.	Six months from now	Sam, Jill, Tom	
Prepare a report for senior management on the need for a key worker system.	1 Circulate ideas for the report 2 Meet to discuss ideas 3 Delegate the writing of the report 4 Meet to modify/ approve the report 5 Circulate the report and lobby about it	Two months from now	Charles, Jane	

You are now in a position as a group to decide which ideas you wish to pursue.

Start with the ideas that arouse most interest, have active support and are considered relatively easy to change. As before, draw up outline action plans giving objectives, actions and target dates. If several ideas involve only a few people it may be possible to divide into subgroups and deal with more than one idea at once.

Carry on until people feel they have committed themselves to enough. Remember that it is better to set a modest objective and achieve it than to overstretch yourselves and fail. Watch out for people who over-commit themselves and may find it difficult to do all they have offered.

Finally arrange for someone to draw up a master action plan that can be copied to everyone, showing what they have agreed to do, as in the example above.

Chart 4

Follow the same procedure as for Chart 3, but this time focusing on *ideas for actions that need to be taken at policy level.*

Presenting your policy proposals

In Croydon the Practice Development Groups were able to feed in policy suggestions to two Policy Forum days which were organised as part of the overall project. These meetings involved a wide selection of people from middle and senior management in health, social services and voluntary organisations and provided an opportunity for people from the Practice Development Groups to present their ideas and proposals.

If your project includes a 'policy day' you will need to plan how best to present your ideas to it. If it does not include such a forum, you will have to explore how best you can work together to pursue changes collectively through the hierarchies you are part of. This may involve you in collecting information, developing arguments, lobbying individuals, writing reports and so on.

As well as or instead of setting up policy days (described in Part 1), it may be useful to put proposals to existing bodies such as Joint Care Planning Teams, Joint Consultative Committees, Joint Chief Officers Groups and Joint Advisory Groups.

URP

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