King's Fund

The Carers Impact Experiment

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CARERS IMPACT
DEVELOPING MAINSTREAM SERVICES FOR CARERS

Published by
King's Fund Publishing
11–13 Cavendish Square
London W1M 0AN

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First published 1996

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ISBN 1 85717 102 0

A CIP catalogue record for this book is available from the British Library

Distributed by Bournemouth English Book Centre (BEBC)
PO Box 1496
Poole
Dorset
BH12 3YD
Tel: 0800 262260
Fax: 0800 262266

Printed and bound in Great Britain by The Cromwell Press, Melksham, Wiltshire

Cover photograph: Sally & Richard Greenhill Photo Library

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Foreword

Experiment and experience in service development

This 'warts and all' evaluation of a pioneering service development initiative comes at a critical point in the implementation of the NHS and Community Care reforms. The Government has acknowledged the achievements of health and social service agencies in restructuring their organisations and putting in place the management and administrative arrangements which are necessary for achieving the key objectives of the reforms. But there is also a clear recognition that now is the time for focusing on achieving better outcomes for users and carers by developing more effective practices and provision.

In response to this service development challenge, efforts are under way throughout the country to explore ways of providing better support to ill or disabled people and their carers. Those involved in these service developments are likely to demonstrate – as they always tend to – energy, enthusiasm and creativity in initiatives aimed at changing long-established practices. They may also find – like others before them – that their attention will be focused mainly on setting up and managing service development ventures while neglecting to assess the impact of these ventures on the lives of users and carers. They may also find it hard to find the time to stand back and reflect on the development process itself, identifying approaches that are facilitating or impeding progress and applying that learning to the work in hand.

The Carers Impact initiative, undertaken between 1992 and 1995, did not fall into that trap. A sizeable investment was made in evaluating the outcomes and processes of change taking place in 13 local areas. The resulting analysis provides illuminating insights into the current state of support for carers in this country and the steps that can be taken to improve that support as an integral part of mainstream community care.

By investing in rigorous evaluation, opportunities have been taken to learn from mistakes and to build on success. The lessons learned during the initiative can and should be taken up by every health and social care agency committed to improving practical support for carers and keen to learn from the experience of others who have already set off down that road.

The key messages arising from this evaluation have a wider application than the world of carers and community care. The strengths and weaknesses of development approaches

adopted here will be recognised by almost everyone currently involved in the development of health and social care services. They will have a special resonance with service development agencies, such as the King's Fund, which devote themselves to stimulating and supporting innovation and good practice in health and social care.

The influence and efficacy of external 'catalysts' in local service development initiatives are considered here, as are the merits of development task forces, the imperative for collaboration within and across agencies, and models for involving people using services in the development process.

The analysis presented in *The Carers Impact Experiment* enhances our understanding of why some development initiatives snowball, going from strength to strength, while others become side-tracked, stall or become bogged down in indecision and inertia. This learning has already informed the design and implementation of new service development programmes at the King's Fund. I hope it will prove equally helpful to others trying to improve health and social care services.

Janice Robinson
Director, Community Care Programme
King's Fund Development Centre

Acknowledgements

This report could not have been written without the unstinting co-operation of the Carers Impact advisers and members of the local task force groups. I hope that the content does justice to the quality of their contribution. My special thanks are also due to the Carers Impact project staff. Michael Powell and Penny Kocher combined sympathetic support for the evaluation task with a thoroughly professional appraisal of the results. Excellent administrative back-up from Caroline Hunter and Isabel Francis meant that a complicated process ran far more smoothly than could reasonably have been expected.

The Carers Impact project was funded by the Department of Health, the Gatsby Charitable Foundation and The Princess Royal Trust for Carers. The project is particularly grateful to the trustees of the Gatsby Charitable Foundation, who made available specific funding for this evaluation study.

Chapter 1

Introduction

What is Carers Impact?

Carers Impact was a national project launched in November 1992 in the wake of the implementation of the Care in the Community reforms as a means of promoting a more effective response to the needs of carers on the part of health and social services organisations in England. It was a bold and ambitious initiative, operating in 13 fieldsites over a period of three years.

The project was based at the King's Fund and run by a small staff team, supported by a steering group whose representatives were drawn from a cross-sector alliance of central government, local and health authority organisations, and national voluntary bodies with a carer focus.

Carers Impact grew from the idea that across the country there now existed a stock of experience and knowledge about carer support which, if analysed and shared, could bring wider benefit. The core of the Carers Impact method was to recruit people with appropriate skills, organise them into small teams of advisers and pair them with multi-agency task groups in the selected fieldsites. This partnership between team and task force group was the motor which drove the Carers Impact process in each area.

The role of the teams was carefully delineated. Their job was not to inspect or prescribe but to work alongside their local colleagues in an interactive and supportive manner. They were to be a resource and a catalyst for local development, drawing upon their own experience but refraining from offering ready-made solutions. The empowerment of the fieldsite groups to manage their own development process was seen as the key to the partnership.

Carers Impact's commitments

Carers Impact was committed to achieving tangible, practical improvements in mainstream services for carers. While recognising the limits of what could be achieved through a time-limited intervention, the thrust of the project was towards major changes in core services,

such as domiciliary care or community nursing, whereby the needs of carers were recognised and provided for at every level, from planning and commissioning right through to provision. Carers Impact was not about tinkering at the edges of the system in order to improve specific carer support services such as telephone lines or information packs. Valuable as these were, they did not represent a developmental challenge and, when compared to the core services, had limited potential for lightening the daily burden of caring.

It was recognised that changes in services would have implications for the processes through which these services were planned and organised. **Process objectives** were therefore embedded within the Carers Impact method. Specifically, Carers Impact sought:

- to support the creation of a strategy for carers across the sectors
- to promote the direct involvement of carers in the planning and delivery of services
- to increase awareness of carers within commissioning and providing agencies
- to encourage special action to meet the needs of carers in Black and other minority communities.

The Carers Impact process

Each team of four advisers was allocated a quota of days to be spent in the field. After piloting the work with the first three teams, the quota was reduced from seven team days to six team days for the remaining ten fieldsites. These days could be used flexibly over the period of intervention at the discretion of the project staff, the team and the fieldsite. The original plan was that each intervention would take place over a one-year period. In practice there was a degree of flexibility, enabling the work in some fieldsites to be spread over a longer period, up to a maximum of 18 months. The needs of the fieldsite, the pace of the development process and the pressures upon the Carers Impact programme as a whole determined the length of each intervention.

In order to ensure consistency in the process and to provide a framework for the teams, a model was evolved which described the Carers Impact process as a cycle of intervention (see Figure 1). The first stage consisted of an audit and diagnosis of the fieldsite's achievements and needs in relation to carer support. The next stage involved the identification from this analysis of specific objectives and tasks for the Carers Impact teams. The third stage was implementation, the 'nitty gritty' phase of following the agreed work-plan. Finally, there was the review of what had been achieved. Each team and task force group were to work in partnership at all stages. Although the team's involvement would end at the conclusion of the

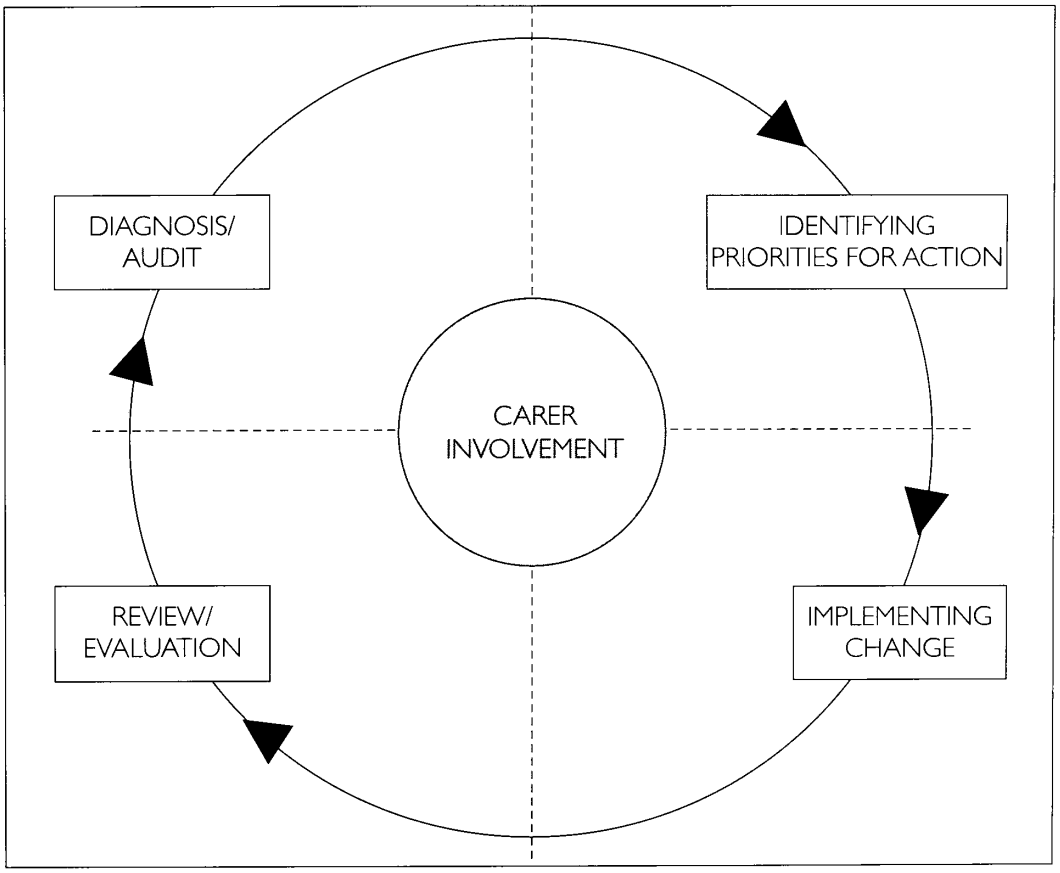

Figure 1 The Carers Impact process

review, it would be possible for the fieldsite group to renew the cycle by taking the findings of the review as a starting point for a new phase of work.

Evaluating Carers Impact

Although Carers Impact was committed to reviewing the achievements of the individual fieldsites and producing an appraisal of the programme as a whole, no detailed evaluation framework existed at the outset. Additional funding made available by the Gatsby Charitable Foundation enabled a formal evaluation process to be designed and built into the work at a later stage. The evaluation used a variety of methods to explore how the key players saw the Carers Impact process and the changes achieved. A detailed, confidential report was written for each fieldsite and distributed to the team and the task force group. More general summary reports which identified common themes were written at different points during the programme.

This publication presents a 'warts and all' analysis of Carers Impact, drawn from the findings of the evaluation. It examines key aspects of the Carers Impact process and considers how far Carers Impact was able to realise its goal of improving services for carers and altering the processes which underpin those services.

Chapter 2

The local contexts

Carers Impact's involvement in 13 widely scattered fieldsites has provided a good indication of the state of development of carer support across the country following the implementation of Care in the Community. In applying for developmental support from the Carers Impact project, the fieldsites mobilised their presentational skills and accentuated the positive. The actual picture on the ground once the teams were in place was rather less encouraging.

Carer support procedures and information

It was clear that the implementation of the Government's White Paper *Caring for People* had stimulated a new recognition and response to carers among the statutory agencies. Some progress had been made in creating assessment procedures which incorporated carers' views (although separate assessment was by no means universal), and there were many examples of Special Transitional Grant monies being used to improve the flow of resources towards carer support.

On the other hand, the implementation process had caused considerable organisational turmoil, to the detriment of carers, at least in the short term. It was frequently reported that carers' issues got lost within agencies' agendas during the upheaval. Responsibility for promoting carers' interests was not firmly located within health and social services structures, with the result that carers were viewed as worthy but marginal. In effect, they were competing and losing against more pressing priorities.

Scattered initiatives had taken place to provide better support for carers but these lacked an organising framework laying down principles and priorities for service development. Carer support developments were therefore ad hoc, characterised by bursts of activity in particular projects and often depending upon the enthusiasm of individual officers. The need for a more strategic approach was widely recognised. Carers Impact was seen by many fieldsites as an opportunity to develop this.

Very little was known about the numbers and characteristics of carers in the fieldsites. Existing information systems were user-centred, and there had been few attempts to derive

estimates of carers in touch with mainstream services, of 'hidden' carers or of Black carers. In essence, there were no systematic procedures for identifying carers at the point of contact with services. In several areas, concerns about this issue had come to centre upon the primary health care team which did not appear to be fulfilling an obvious function for carers in providing access to a wider network of support services.

Collaboration strategies and carer participation

Despite this general pattern, the need to listen to carers was widely recognised, and efforts had been made in most areas to seek out their views through research exercises and consultation events. Generally lacking, however, was a robust infrastructure of representative carer bodies through which a regular dialogue with carers might be sustained.

This had important consequences for the involvement of carers in formal structures for planning and implementing services. Such involvement was generally weak and tokenistic. Statutory authorities often relied upon a small number of hand-picked carers to provide the 'carers' viewpoint'; alternatively, local voluntary organisations with a carer focus were drafted in to offer this perspective by proxy. Either way, the authorities were not being fed the full range of authentic views and experiences from carers who were currently at the sharp end of their services.

A surprising feature of the local contexts was the underdevelopment of collaboration between the statutory services, in particular between health and social services. The applications to Carers Impact had consistently emphasised the excellence of relationships between the sectors and the push to develop joint commissioning and purchasing. With regard to carer support, however, there was little evidence of a constructive joint approach beyond the occasional shared funding of a carer project.

Poor communication seemed to pervade relationships at every level. In none of the fieldsites had senior managers within the different services come together to work out a planned approach to carer support. Only one example of a multi-agency carer support strategy was found; this strategy had been initiated and written by the social services and endorsed by the health service. Further down the hierarchy, there were no procedures to ensure that there was a co-ordinated approach to meeting carers' needs. Of particular concern was a persistent failure of communication between general practitioners and social services. Without adequate liaison between these key services, carers were in effect left to co-ordinate their own support systems.

There seemed to be a widespread but unspoken assumption that carers were fundamentally a health and social care issue. Thus there was minimal involvement of other local services, notably housing and education, despite the huge potential of such services for influencing the circumstances of carers' lives. Carers with the most specialist and complex needs, such as parent carers of severely disabled children, were left to struggle with inflexible and fragmented services when they most needed sensitive co-ordination of support provision across a range of agencies.

The deficiencies in collaboration were mirrored in the task force groups set up at the beginning of each local Carers Impact initiative. In most areas these multi-agency groups were assembled in some haste before the Carers Impact teams arrived, giving their members little opportunity to experience working together or to build up trust and the beginnings of a shared vision. Carer involvement in the groups was minimal at the outset, and the carers concerned were not linked to carer networks which might have offered them support and guidance in their role. Representation of statutory services, apart from health and social services, was non-existent, with the exception of one area in which the education service made a contribution, although this was not at a senior management level.

Underpinning these organisational characteristics which had inhibited the development of adequate carer support were deep-seated cultural and attitudinal patterns. A focus upon the user was built into the organisation of services at every level and permeated staff attitudes. As a result, the needs and views of carers were marginalised. One of the greatest challenges identified by the participants in the Carers Impact project within the fieldsites was to persuade their colleagues to 'think carer'. There was a general failure to recognise carers as partners in the provision of community care or to be aware of their distinctive needs. Organisational change and resource constraints tended to entrench these attitudes more deeply. The fear seemed to be that by being more open to carers, services would be taking on a huge new area of need which they could not hope to meet.

Within this broad picture there were of course differences between fieldsites in the extent to which they had developed carer support. There were a few examples where authorities had sought to raise the profile of carers through sympathetic policies and a determined drive to provide practical services. In these areas the voluntary sector had been particularly forceful in lobbying on behalf of carers and pressing for specific improvements. However, these initiatives were always unilateral rather than multi-agency and they often made little impact upon the underlying problem of mainstream services which were poorly adapted to providing carers with the support they needed.

Complexity of carers' needs

The best-developed fieldsites perhaps illustrated the complexity of carers' needs more sharply than those areas which had a generally poor level of provision. It became clear, for example, that even where key support services such as information and respite were in place, these were not uniformly accessible or beneficial to all groups of carers. Cultural and linguistic barriers discouraged carers in minority ethnic groups from claiming equal access to services and from representing their views within the planning process.

In other cases, it was the nature of the caring task which made it difficult to reduce carers' sense of isolation. Carers of adults with mental health problems were usually involved in acute but intermittent episodes of caring. Identifying themselves as carers and negotiating the level of support they needed proved to be more difficult than for those who were coping with a stressful but predictable daily routine. There were also carers, notably the above-mentioned parent carers of children with severe disabilities, who depended upon a range of highly specialist interventions and for whom general carer support services had limited relevance.

It was against this intricate background that the 13 Carers Impact teams were established with the aim of assisting local areas to bring about tangible, practical improvements in carer support. It soon became clear that the task was potentially enormous, involving not just grappling with the details of service provision but also changing attitudes and systems. One fieldsite participant described the experience of trying to induce change on this scale as 'walking through treacle', perhaps an appropriate metaphor for the Carers Impact process.

THE LOCAL CONTEXTS – KEY POINTS

- The implementation of Community Care had simultaneously raised the profile of carers and made their needs more difficult to meet in the short term.

- Scattered initiatives had taken place to develop carer support but there was no organisational framework for development.

- Little was known about the numbers and characteristics of carers within each area, and there was no means of identifying carers at the point of entry to services.

- The need to listen to carers was widely recognised and their views had been sought through special consultation exercises; however, the involvement of carers in formal planning structures was weak and tokenistic.

- Collaboration between health and social services on behalf of carers was seriously under-developed at every level, and there was only one example of a multi-agency strategy for carer support.

- Carers were seen as a health and social care concern; other local services with important implications for the well-being of carers were not involved as key players in the development of carer support.

- Deficiencies in collaboration were mirrored in the composition of the task force groups which were set up at the beginning of each Carers Impact initiative.

- A focus upon the user rather than the carer was central to the culture of service organisations and permeated the attitudes of staff. As a result, the needs of carers were marginalised.

- There were important variations between fieldsites in the extent to which they had worked to develop carer support, but even in the best-developed areas some groups of carers, including those in minority ethnic communities, found it more difficult than others to obtain access to the help they needed.

Chapter 3

Negotiating the entry of Carers Impact

The entry of a Carers Impact team into a fieldsite was perhaps the most critical stage of the intervention. The success of the initiative depended upon the team being able to establish a successful working relationship with the local task force group, based upon agreed objectives. Achieving this proved to be more difficult than had been anticipated. The evaluation was able to pinpoint a number of underlying reasons for this, and it also highlighted factors which promoted good relationships.

Selecting the fieldsites

The fieldsites were chosen in order to provide a good geographical spread and a wide variety of approaches to carer support. Some fieldsites had focused their attention on particular groups of carers or a specific part of the service system, such as primary health care. Others were seeking to raise the general level of their response to carers. The aim was to achieve diversity within the project while maintaining common standards for selection.

The selection process posed formidable diagnostic problems for the project staff. They wanted to select areas in which the Carers Impact process had a good chance of success and they had evolved set criteria by which they could assess the fieldsite's readiness. The difficulties came in interpreting information about complex local conditions and relationships.

The first stage of the selection process was a written self-assessment by the fieldsites based on the Carers Impact criteria. The fieldsites needed to demonstrate:

- a high level of commitment to responding to carer needs within the development of community care
- a willingness to work co-operatively across the service sectors – statutory, voluntary and independent – in developing carer support
- a capacity to draw together a multi-agency task group to work in partnership with a Carers Impact team

- a commitment to consulting carers and involving them in planning and implementing service developments
- a commitment to involving both purchaser and provider interests in developing carer support.

There were two problems. First, the criteria were framed in terms of *intentions* and *willingness,* rather than solid achievement, allowing respondents to give a very positive gloss to their responses. Consequently, as suggested earlier, the fieldsites later proved to be far less developed in key areas, such as carer involvement and collaborative initiatives, than had been supposed. This is not to suggest that applicants deliberately misrepresented the facts; rather, when invited to compete for a scarce resource, they tended to emphasise positive aspects and minimise deficiencies. During their preliminary visits to the fieldsites – the second stage of the selection process – the Carers Impact project staff showed considerable penetration in identifying likely problem areas. However, they tended to overestimate the extent to which the fieldsites were able to act upon their suggestions and make changes which would give the partnerships the best chance of success.

The second problem was that the senior officers who formulated the local bids to the Carers Impact project rarely maintained a commitment to the initiative beyond the stage of the initial negotiations. Once the resource had been obtained, responsibility for developing it was passed down the hierarchy, often to people who had had no stake in the bid and little knowledge of what Carers Impact might involve. The generally poor level of preparation and consultation within the fieldsites before involving Carers Impact became a significant disadvantage for the teams.

These difficulties might have been avoided by a tighter approach to the initial negotiations and by written agreements which specified conditions such as continuing senior management involvement and the range of interests which needed to be represented in the local task force groups. But this approach was antithetical to the style of Carers Impact, which was to be helpful, enabling and non-prescriptive.

Selecting and briefing the teams

The recruitment of advisers for Carers Impact was a fairly informal process. Publicity through the professional press invited applicants to submit a c.v. with a supporting statement indicating why they wished to work with the project. About half the applicants who responded were invited to attend a preparatory workshop. Two workshops were held, producing a pool of

about 60 advisers, most of whom were subsequently invited to join a fieldsite team. Each team comprised four advisers, at least one of whom was a carer.

In choosing advisers for a particular fieldsite, the Carers Impact project staff looked for strong all-purpose teams with a balance of management and development expertise, preferably gained in diverse organisational settings, as well as direct carer experience. In those areas where a specific issue had been identified as the focus for the intervention, efforts were made to find advisers with appropriate skills. Generally, however, there was limited scope for fine-tuning the match between the team and the fieldsite. This was partly because the fieldsites' needs were ill-defined initially but also because Carers Impact was constrained by the expertise available in the pool at any one time.

A briefing day was held for each team prior to the first fieldsite visit. The briefings were based upon the large volume of written information supplied by the fieldsites and upon the informal, first-hand observations of the project staff following their preliminary visits. The general consensus was that the briefings were helpful in giving an 'aerial' view of the most exposed features of the fieldsites, such as their organisational structures and their community care plans, but that the really interesting detail lay in the networks and relationships which could only be observed closer to the ground.

There was some controversy about the value of involving fieldsite representatives in the briefing process. Some team members felt strongly that their presence helped to breathe life into the picture, giving a real flavour of pressing local issues. Others believed that the presence of an outsider made it more difficult for the team to bond. They also considered that the views of only one or two people from the fieldsite might unduly colour their own perceptions.

A second function of the briefing day was to give the team members time to get to know each other and to learn about their various backgrounds and skills. Once again, the dominant view was that although the session offered a useful beginning, a strong team identity could be forged only through the pressures of working together on site.

Perhaps the most serious question which the evaluation raised about the briefing process was the extent to which it equipped the teams to negotiate the entry into the fieldsites. The teams were entrusted with a delicate balancing act. On the one hand, they were urged to be active champions of Carers Impact values; on the other, they were instructed to foster local self-determination. It was not their role to set the agenda for the work but to enable the local task

force groups to do so and then to work with them in achieving their objectives. This was a client-centred approach to development in which the values of openness, responsiveness and flexibility were central and the need to work at the pace of the fieldsite was paramount.

It could be argued, however, that this approach disempowered the teams by depriving them of a positive strategy for handling their initial meetings on site. In particular, they needed a more robust diagnostic procedure to help the fieldsites define their strengths and weaknesses and to provide a firm platform for the working partnership.

The entry phase

For the Carers Impact advisers, the initial site visit provided the first opportunity to function as a team. Relationships and working methods were still untested, although the presence of a Carers Impact project staff member did provide an important element of support and continuity.

The fieldsite task force groups were also at the earliest stages of forming. In many areas Carers Impact had prompted local agencies to come together for the first time around carer issues. Often, their first meeting had been organised to coincide with the arrival of the Carers Impact team; at most, they had had one or two previous meetings. The members of the task force groups therefore knew little about each other as individuals or about the structures within which they each worked. There had been no time to find out about the range of carer-related work that was being undertaken or to explore perceptions of what needed to be done. They were a long way from defining priorities for Carers Impact.

The juxtaposition of a new Carers Impact team and a task force group which lacked a sense of common purpose and cohesion did not promote successful engagement. The task force groups looked to the adviser teams for direction and guidance. They expected an analysis of their local situation, some clear options for how to proceed and models drawn from other areas which might be adapted for their own use. The adviser teams were neither equipped nor briefed to fulfil this function. Their role, as explained by the Carers Impact project staff, was to help each fieldsite define its own agenda and to work in partnership with the local task force group to achieve the detailed objectives.

The frequent result of this mismatch of expectations was a sense of confusion and frustration within the task force group which was turned upon the Carers Impact project. The group found it difficult to understand what resource was being offered and what practical benefits

might be gained. They questioned the value of Carers Impact's presence if, as it appeared, the advisers were to have no 'hands-on' involvement in the development process. In some areas a debate about the role of the advisers consumed a great deal of energy in the early stages, diverting attention from the task in hand.

This scenario applied, to a greater or lesser extent, in all the fieldsites but was exacerbated when:

- the task force groups were very large
- the task force groups lacked clear leadership
- the agenda for the meetings between teams and task force groups was unfocused
- the meetings took place in formal or very enclosed settings which prevented informal contact between team and task force group members.

The underlying problem, however, was the timing of the Carers Impact intervention. The task force groups were simply too new and unfocused to engage constructively with the adviser teams. They badly needed external facilitation in order to achieve a shared identity and sense of their own priorities. The Carers Impact model did not allow for this and the team was not the right instrument for achieving it. The need for a single, skilled facilitator to prepare each task force group for Carers Impact was clearly indicated by the evaluation.

Audit and diagnosis

The first stage in Carers Impact's circular model of intervention involved carrying out an audit and diagnosis of existing provision for carers and of unmet carer needs. In the absence of any checklist or framework which might have guided the process, the early visits of the teams were in practice devoted to gathering impressions of local conditions for carers.

Sometimes these were conveyed through formal presentations by the key players in the fieldsite. A great deal of information could be communicated in this way but it put the teams in rather a passive position, limiting their capacity to question and explore. A more successful approach, used in several fieldsites, was to set up a series of independent meetings for the teams through which they could talk to service representatives and groups of local carers. This sometimes proved exhausting but it provided the teams with a rich variety of information and access to alternative viewpoints. First-hand contact with carers at an early stage was particularly important as a demonstration of the teams' willingness to be guided by carers' perspectives.

A weakness of the Carers Impact process was that there was little opportunity for the teams to spend time together at the end of each visit in order to draw their impressions into a coherent shape. As a result, their feedback to the fieldsites tended to be rushed and unstructured. Sometimes, however, the teams did prepare short written reports to supplement the verbal feedback and these proved a helpful means of identifying priorities. Written reports could have been used to greater advantage in the programme as whole as a means of feeding in the teams' collective views at key points in the development process.

Agreeing objectives and tasks

Despite the difficulties which beset the entry of Carers Impact, in most cases the team and task force group were able to negotiate a viable arrangement for working together. An effective task force group leader with a positive attitude to working with the team was the single most important factor in achieving this breakthrough. Nonetheless, reaching agreement on objectives and tasks was often a prolonged process, sometimes consuming half of the time allotted to the teams. In one fieldsite, the entire time was spent negotiating objectives.

Clear and realistic objectives allowed teams and task force groups to work together in a focused way and marked the beginning of a more constructive phase in their partnership. The team advisers began to apply their separate skills to the detailed tasks in hand, finding their role more fulfilling as a result. In some fieldsites, however, the early problems in defining a function for the team persisted throughout the intervention. In these cases the advisers remained on the sidelines, commenting upon the progress of the task force group and offering encouragement, but with little close involvement.

The objectives and tasks pursued were in almost all cases tangential to Carers Impact's central objective of achieving improvements in mainstream services for carers. The withdrawal of senior managers from involvement in the task force groups was certainly one factor which limited the scope for negotiating an agenda of service change. However, it is likely that even if their support had continued, most fieldsites would not have been ready to tackle service change in a co-ordinated and purposeful manner. Thus, Carers Impact quickly became refocused upon intermediate outputs which could be delivered by the task force groups. These were of three main types: strategic frameworks for the development of carer support; initiatives to improve carers' access to existing services; and programmes to improve awareness of carers among service professionals.

The entry of Carers Impact – Key points

- It proved difficult to diagnose how ready a fieldsite was for Carers Impact from the information which accompanied the application.
- The rapid disengagement of senior management following the early negotiations was an unexpected setback. In general, there was a poor level of preparation for the arrival of the Carers Impact adviser teams.
- In selecting the advisers for a fieldsite, Carers Impact sought to achieve a balance of management and development skills rather than to fine-tune the selection to the needs of the fieldsites.
- The Carers Impact briefings for team members gave a good general view of the fieldsites but did not offer a robust strategy for handling the entry phase.
- Successful engagement with the fieldsites was hindered by the lack of cohesion within the task force groups and by confusion about the role of the Carers Impact adviser teams.
- Independent meetings with local service providers and carers proved to be a good way of integrating the adviser teams into the fieldsites.
- Structured feedback from the adviser teams after their initial visits proved helpful to the fieldsites in identifying their priorities.
- In most fieldsites, the adviser teams and task force groups were able to negotiate achievable objectives for the work although this took longer than anticipated.
- It was not possible for the Carers Impact project to negotiate an agenda for changes in mainstream services. The Carers Impact initiatives became focused upon intermediate outputs.

Chapter 4

Building an effective local task force group

Building a stable and cohesive local task force group to work in partnership with the Carers Impact project proved to be a major challenge. The evaluation has helped to identify the main components of a successful group and some of the pitfalls that were encountered.

Leadership issues

The quality of leadership in the task force group emerged as a primary factor in the progress of the Carers Impact work. Identifiable leaders who were committed to bringing about improvements for carers and who saw Carers Impact as a lever for achieving change created a purposeful, receptive atmosphere within their groups. This fostered a desire for a constructive partnership with the advisers, even if there were initial fumblings around their role.

The ideal scenario was for the leadership of the group to be assumed by the same person who had co-ordinated the application to Carers Impact. Consistent involvement of a key player promoted a continuity of purpose around the initiative, and this made it easier to formulate detailed objectives. Unfortunately, this condition was achieved in only four of the 13 areas. Elsewhere, responsibility for co-ordinating the Carers Impact work was delegated lower down in the organisational hierarchy. Although this disjunction created confusion, several task force groups managed to select leaders who proved capable of embracing the initiative and successfully refocusing it.

Strong leadership had a downside. There were examples of heavily committed people who assumed a personal responsibility for the progress of the work and who were poor at delegating tasks to other members. This diminished any sense of ownership and involvement within the group as a whole. At worst, the strong leader at the core came to be surrounded by an ever-changing succession of participants at the periphery.

Over-committed leadership was, however, preferable to no leadership at all. In some fieldsites the task of working with the Carers Impact project had been delegated to large, powerless and

leaderless groups. In these circumstances it was particularly difficult to achieve a good working relationship with Carers Impact. The need for direction led to acute frustration with the teams when they failed to provide it.

Resourcing the task force group

In general, senior managers who prepared the bids for Carers Impact did not consider or plan for the costs of becoming involved. In effect, they treated Carers Impact as a free resource. There were, however, quite substantial implications for staff time as well as financial costs in providing administrative support and organising events. Given that senior managers tended to disengage themselves quite quickly, these costs were devolved onto people lower down in the hierarchy who had not been party to the application process and who in some cases felt that they had little choice about their involvement.

Staff, often already overstretched, had to take on the initiative in addition to their normal workloads. For the task force group leader, this additional commitment could be substantial, incorporating both a co-ordination role in the group and a liaison function with the project. The lack of recognition for the extra work, coupled with a sense that the initiative had been wished upon them from above, tended to dampen the enthusiasm of task force group members.

On the other hand, injections of resources into the Carers Impact work helped the task force groups to make rapid progress. In one area, for example, social workers were assigned to support a programme of development work within primary health care teams. In another, funding was made available to employ a temporary worker to undertake a sample survey of carers in three general practices and subsequently to support a mobile exhibition which could reach all practices within the borough. These extra resources meant that agreed tasks could be pursued in a more efficient and concentrated way, but they also had an important symbolic value, signalling to the group that their efforts were acknowledged and valued.

The evaluation suggests that resource issues should have figured more strongly in the early negotiations between Carers Impact and the fieldsites and that, in particular, the need for some dedicated worker time to support the development process should have been addressed.

Linking into the planning process

The positioning of the task force group in relation to the community care planning process emerged as a significant issue, particularly where the group had taken on the task of

developing a strategic framework for carer services. There were examples of task force groups assuming the role of working groups within the joint planning machinery, feeding carer issues into service planning. This kind of structural link provided the best opportunity for embedding a carer dimension into service development. It also gave a recognised status to the task force group. An alternative type of linkage was achieved when joint planning officers participated as members of task force groups; however, in such cases, the impact upon the planning process depended largely on the effectiveness of individuals as ambassadors for carers.

In the aftermath of the Community Care reforms, several fieldsites were undergoing a total reconstruction of the joint planning machinery. This meant that there was no formalised process which could be influenced by the Carers Impact initiative, and the task force groups therefore floated freely, seeking to exercise influence through the personal networks of their members. This situation was far from ideal but it did offer the groups an opportunity to develop their strategic thinking so that they would be in a better position to exert pressure upon the new system. The Carers Impact teams helped the groups to recognise this opportunity and to sustain their commitment to a strategic approach against a background of considerable upheaval.

Membership issues

Achieving a strong carer presence in the task force groups proved difficult in almost all areas. The reasons for this and the means through which better representation was in some cases achieved are discussed more fully in Chapter 5.

As noted earlier, the composition of the task force groups faithfully reflected pre-existing relationships within the fieldsites. Thus, just as carers had a muted voice, voluntary bodies were rarely able to participate as equal partners. Those who were recruited to the task force groups were mainly small service providers or those who were seen to represent the carer voice. These organisations seemed peripheral to the thinking of their statutory partners. A rather different pattern applied in one or two fieldsites in which responsibility for developing carer support was seen as a voluntary sector issue and had been delegated to a key voluntary agency. Although this agency became a principal player in the task force group, it was burdened with the same expectations within the group as outside it. In other words, it was expected to do most of the work.

Perhaps the most constructive partnerships between statutory and voluntary sector members emerged in two areas where carer centres had been established. The carer centre

representatives proved to be effective champions for improved carer involvement in Carers Impact work and they also brought an overview of carer support needs which was firmly grounded in their day-to-day contacts with a wide range of local carers.

The core membership of each task force group was drawn from health and social services, reflecting the narrow boundaries within which carers' needs are commonly defined. Housing, transport and education, which are responsible for services central to carers' lives, were hardly touched by the Carers Impact process. This partly reflects an absence of strong working relationships between sectors and local government tiers, but it was perhaps also a consequence of the project approach, which began by seeking to achieve agreement between agencies about a broad plan for carers, rather than by identifying a specific carer need and to build consensus through working to achieve it.

Between the health and social services representatives, power imbalances were sometimes evident. It frequently proved difficult to integrate them as equal partners because of differences in the seniority of the personnel involved and because of varying levels of personal commitment. In addition, the wider organisational context affected their involvement. For example, members who were experiencing severe resource constraints within their own organisations found it more difficult to give their time to the Carers Impact work and were unable not be so wholehearted in supporting developments which had obvious resource implications.

Another source of imbalance was that task force group members were primarily drawn from middle managers with policy and planning responsibilities. The involvement of providers and practitioners was less pronounced. In particular, it proved difficult to draw in provider health trusts and general practitioners despite repeated invitations from task force group leaders. Once again, the lack of a specific service focus may have been an inhibiting factor. Some task force groups were successful in recruiting social services staff with 'hands-on' experience of carer support. This worked well, resulting in a cross-fertilisation of ideas and a more democratic atmosphere within the groups.

Whatever the composition of the task force group, it was important to achieve a degree of stability in the membership. A constant turnover of members undermined agreed objectives and made it difficult for the group to keep to its task. There were occasional examples of new members turning up, making an intervention which deflected the group from its agreed course and then disappearing. Focused working around clear objectives proved to be the best means of keeping members interested and involved.

Working to clear objectives

The confusion and frustration which surrounded the entry of the Carers Impact teams had a damaging effect upon the cohesion of the task force groups. A falling off of interest and a sense of drift were common effects. The pace picked up considerably if task force group and Carers Impact team were able to agree on objectives which were manageable and clear, with time-scales attached. These gave focus to the work and a practical basis for partnership. The task force groups benefited from the sense of achievement which came when goals were reached, and this acted as a stimulus for further progress.

Dividing into sub-groups to work on particular objectives proved to be an economical and effective approach. Where this method was adopted, the Carers Impact advisers would usually attach themselves to the sub-groups singly or in pairs according to their particular interests and expertise. This flexible approach made it easier for the task force group members to harness the skills of the team. Also, working within a narrower framework enabled the sub-groups to identify and pull in local sources of help (for example, people with research and training skills) to assist with specific aspects of the task.

The ideal task force group

Not surprisingly, the fieldsites varied enormously in the strength of their task force groups. A few continued to flounder for the entire period of the Carers Impact intervention while, at the other extreme, there were groups which achieved a strong and committed membership, including a good level of carer representation, and which worked to realistic objectives within a clear action plan. The majority of groups fell somewhere in the middle, often starting hesitantly but achieving a degree of cohesion and some worthwhile outputs by the end. Although the ideal task force group was elusive in practice, the indicators of success were reasonably clear and are summarised overleaf.

COMPONENTS OF THE IDEAL TASK FORCE GROUP

The Carers Impact evaluation has suggested that the ideal task force group would be built from the following components:

- sustained involvement by senior management
- a leader who is able to involve other members of the group as equal partners, sharing out the workload and fostering a sense of ownership
- earmarked resources for the administration of the group and dedicated worker time for pursuing agreed tasks
- a clear structural link into the community care planning process
- strong and varied carer representation, enabling the group to be driven by carers' needs
- the involvement of appropriate voluntary sector bodies as equal partners
- a broadening of statutory sector representation beyond the health-social services axis
- a good balance between purchaser and provider interests, with practitioner representation to ensure that a service delivery perspective is embedded into the work
- a stable membership
- clear and manageable objectives, and a sensible division of tasks to achieve them.

Chapter 5

Achieving real carer involvement

Carer participation, individually and collectively, in the planning and development of services was was seen as essential in the Carers Impact work if the needs of carers were to be met appropriately. Carers Impact looked for the active engagement of carers in the work of the local task force groups as a means of stimulating this partnership, particularly in areas with a poor record of carer participation. The extent of this engagement must therefore be seen as a measure of the success of the Carers Impact process.

The background to carer involvement

Very few areas had a strong tradition of carer representation upon which to build. Some of the obstacles which had hindered carer involvement in the past have been referred to earlier and they may be summarised as follows.

- Networks through which the service authorities might have conducted a dialogue with carers had not been built. Consultation was therefore intermittent and ad hoc.
- Carer forums existed in a few areas but had generally not been resourced and supported so as to enable them to be active partners in the planning of services. Carers therefore lacked representative structures through which to channel their concerns.
- Even when positions for carers had been allocated within planning structures, the actual level of representation was much lower than indicated because of the lack of a supportive infrastructure.
- Attitudes towards carer involvement on the part of statutory sector officers were ambivalent. Some had been put off by angry confrontations with carers in the past; others were more favourably disposed but worried about how to achieve a representative carer view.
- Proper preparation and support for carers involved in formal structures had not been provided.
- In some instances there was a tension between user and carer involvement. User involvement had been actively pursued in several fieldsites; concern was expressed about how to maintain a balance between the interests of the two groups if carers were given equal status.

Poor carer involvement had quickly been picked up as an issue by the Carers Impact project staff in their preliminary visits to the fieldsites, and their misgivings had been clearly signalled. They wanted strong carer representation within the task force groups and a wider dialogue with carers as part of the development process.

Involving carers in the task force groups

In tackling the issue of carer recruitment to the task force groups, most fieldsites demonstrated a disappointingly hesitant and minimalist approach. Either they selected one or two carers who were personal contacts of members of the group or they drew in a local voluntary body with a carer focus to represent the carer viewpoint. Thus they disposed of the thorny problem of how to reach out to a wider constituency of carers. But in doing so they lost much of the vibrancy of the carer contribution.

Although the carer representatives were able and dedicated people, there were few current carers among them. It was notable, too, that when the work focused on a particular group of carers, such as those caring for mentally ill people, the groups failed to involve carers with this specialist experience. In general, there was a gap between the carer representatives who could provide a general perspective on carer issues and current carers who did not have a voice but who were experiencing the reality of service provision from day to day.

There were a few examples of key task force group members who had access to carers through their own networks acting to block wider carer involvement. This was usually because they were jealous of their status as the carer voice within the group but sometimes the reasons were more complex. In one fieldsite, for example, a dispute between community development workers and managers within social services restricted the capacity of the task force group to make links with a carer forum which the workers had facilitated.

A notable exception to this rather discouraging picture was one task force group which took as their starting point the need to involve a large number of carers so that they formed the majority in the group and would be in a position to drive the initiative. These were all 'raw' carers who were actively absorbed in the caring task and who had no previous background of working within formal structures. Their strength was that they could speak from authentic experience and support each other within the group.

The latter approach to carer involvement perhaps offers a challenge to Carers Impact's thinking. Despite recognising carer involvement as a central issue, there was a tacit

acceptance on the part of the Carers Impact project that the nub of the problem was how to draw carers into a professional setting. Perhaps the problem needed reformulating. Task force groups moulded around a core of active carers, with the professionals in a supporting role, might have provided a better basis for dialogue and partnership.

Extending the dialogue with carers through Carers Impact

Direct participation in the task force groups was just one aspect of carer involvement. Beyond this, Carers Impact offered opportunities for carers to participate in consultation events and, in some cases, to help the task force groups in carrying out their development programmes. Carer involvement in this wider sense was actively encouraged and facilitated by the Carers Impact teams. Practical, constructive experiences of working with carers allayed the anxieties of professionals. A strengthening of carer representation in the task force groups was sometimes the result, demonstrating that different modes of carer involvement could be mutually reinforcing.

The Carers Impact teams promoted carer participation in a number of ways. Most dramatically, they offered a robust challenge to entrenched attitudes. In one fieldsite, for example, a poor turnout of carers at a key consultation event prompted the adviser team to scrap the programme for the day and instead to conduct a brainstorm on carer involvement. A decision to set up two carer forums was the direct result. Elsewhere, a Carers Impact team threatened to withdraw their support unless substantial carer representation was sought for a major conference. It was then decided that professionals could attend this event only if they brought a carer with them. Several of the carers who attended subsequently became involved in the task force group.

Such a direct approach was not always appropriate or necessary. More often, the teams worked indirectly to support the task force groups' own efforts to reach out to carers. Some groups developed a momentum of their own on this issue and needed very little input from the team; however, it was often the team's initial stance on carer involvement which had provided the stimulus. Specific gains in carer involvement achieved through the Carers Impact process included:

- consultation with carer groups to validate a carer strategy which had been drawn up in outline form by a local task force group
- the establishment of a regular forum through which day-care centre managers and carers could discuss how existing resources might be better deployed to support carers

- the involvement of carers as partners in formulating a carer awareness training package
- intensive consultations with groups of carers in 'pilot' general practices in order to establish a profile of carer needs
- the co-opting of four carers onto a social services committee following direct representations from a task force sub-group on carer involvement.

A point repeatedly made was that a desire to be more open to carers had already been present before the arrival of Carers Impact and was one of the benefits of the implementation of the Community Care reforms. Carers Impact provided an opportunity to build upon this impetus and to translate it into innovative exercises in carer involvement.

Sustaining carer involvement over the longer term

Ensuring that carer involvement became part of the local furniture, rather than a series of ad hoc exercises, was a bigger challenge. Unless a continuing dialogue with carers was anchored into the system, they would always risk being marginalised whenever their contribution became inconvenient or perhaps too costly to obtain.

The development of an infrastructure to support carer involvement featured in only one of the 13 fieldsites as a central theme of the work (although there were several areas where this was being pursued outside the Carers Impact initiative). In this fieldsite there were dramatic gains in carer involvement and in the momentum of the initiative. The development process had some well-defined features which contributed to a successful outcome, including:

- efforts were made to liaise with carer groups across the county and to identify a core group of interested carers
- a consultation meeting was held with carers in the hope of generating their support for a forum. This was facilitated by members of the Carers Impact team who promoted the idea and shared their experiences from other areas. As a result, the carers decided to set up two forums for the north and the south of the county
- the forums had a defined role and some real power. The implementation of a carer strategy which had evolved through the Carers Impact initiative was put under their direction. They assumed responsibility for monitoring the strategy and for reporting back through the joint planning process and to the social services committee
- those who were charged with continuing the work begun under Carers Impact now became accountable to local carers. Carers used to waiting patiently for changes to happen began to set the agenda. One carer said, 'Now that carers have a voice, they won't let go.'

This suggests that careful preparation and consultation to generate a groundswell of support from carers are a necessary foundation for a carers' representative structure. Once established, it must have a measure of real authority and clear links to the planning process in order for carers to feel that their involvement is worthwhile.

Overall, the Carers Impact project demonstrated that successful carer involvement has three complementary strands. The first is outreach to carers in the community through the use of imaginative and flexible approaches to consultation. The second is the formal representation of carers in the planning process. And the third is the evolution of a representative base which enables carers to speak with a collective voice.

CARER INVOLVEMENT – KEY POINTS

- Few areas had a strong tradition of carer involvement upon which to build when the Carers Impact teams arrived.
- Carer involvement in the local task force groups was generally weak and tokenistic, with an over-reliance on 'hand-picked' carers and local voluntary organisations to represent the carer viewpoint.
- 'Raw' carers with current experience of services were rarely involved.
- Those who undertook to represent the voice of carers within the task force group occasionally blocked access to wider networks of carers.
- Carers Impact's main contribution was to stimulate new approaches to carer consultation and involvement. This strengthened the local task force groups and, in some cases, led to improved direct representation of carers.
- The need was strongly indicated for a representative base for carers to support their involvement in formal structures.

Chapter 6

The Carers Impact partnerships

The problems which hindered constructive engagement between the Carers Impact teams and the local task force groups have been explored earlier in this report. It has been shown how attempts to dissipate the confusion over the role of the teams consumed considerable time and energy in the early stages of each intervention, and how this delayed the development process. This pattern was universal across the fieldsites. Once, however, a measure of agreement had been reached as to the objects of the intervention, very different partnership styles began to emerge. This chapter presents three models of collaboration constructed from the fieldwork evidence and analyses their main features, with some illustrative case examples.

Model 1: The fully committed partnership

This was the most rewarding form of collaboration and the one where the potential of the Carers Impact intervention was most fully realised. It was based upon a high level of personal and professional rapport between the Carers Impact adviser team and the task force group. Work priorities were clearly defined, and the advisers understood their part in delivering them. Their individual skills were appreciated and used by the fieldsite, and there was much scope for creative involvement alongside their local colleagues. At the same time, the advisers were able to use their greater detachment to positive effect by maintaining an overview and encouraging the task force to develop a strategic approach to complement the more task-centred activities. Team and task force group were able to plan the work together, enabling the Carers Impact project staff to take up a supportive position in the background. This direct communication between the team and the fieldsite accelerated the momentum of the work.

A fully committed partnership was achieved in perhaps four of the 13 fieldsites. The factors which were most clearly associated with this level of involvement were:

- a task force group leader determined to use Carers Impact as an instrument of change
- an assertive adviser team prepared to make challenges and offer ideas without dominating
- strong facilitation skills within the team
- a flexible approach by the task force group to using the expertise in the team, such as involving the advisers singly and in pairs to exploit their individual expertise fully

- a focused approach by the task force group to working on agreed tasks (for example, by forming sub-groups to undertake specific parts of the action plan)
- a willingness by the fieldsite to share ownership and recognition of the work with Carers Impact
- a strong team identity among the advisers (although it is not entirely clear whether this was a cause or effect of constructive involvement)
- a fortuitous match between the resources available within the team and the needs of the fieldsite.

CASE EXAMPLE: FIELDSITE A

The Carers Impact team hit this fieldsite running, with a packed two-day itinerary of meetings with local interest groups, including carers. The local task force group had developed some reasonably clear ideas about what they wanted to achieve; these were sharpened by the verbal and written feedback from the team. Subsequent negotiations were slow but six priority areas for development were eventually whittled down to two, and the team members then worked in pairs to support each strand of the work. It was particularly fortunate that the division of interests and skills in the team almost exactly matched the chosen objectives. One pair helped the fieldsite to draw up a specification and funding proposal for a carer development worker; the other became involved in designing a work programme to promote carer awareness within primary health care teams. The team added value to the task force group's own efforts by acting as independent facilitators to workshops for local professionals, sharing models of good practice drawn from their own networks, ensuring that carers were involved in local consultation processes, and generally putting pressure on the fieldsite to keep things moving. A task force group colleague said:

> *'Because of their knowledge and experience, they have enabled us to be more objective in our discussions and conclusions. I feel they have really moved us forward in a practical way in terms of co-ordinating and improving services for carers.'*

Model 2: The semi-detached partnership

Here the objectives for the work were reasonably well defined but the adviser team did not become closely involved in delivering them. The work was done by the task force group, with the team supporting from the sidelines. The meetings held at intervals to review progress gave

the team an opportunity to inject comments and ideas. Whether these were then acted upon depended almost entirely on the discretion of the task force group since the advisers had little stake in the action.

Typically, team and fieldsite had no direct contact between visits, communication being mediated through the Carers Impact project staff. The task force group needed repeated prompting from the project staff before calling in the team and long intervals thus elapsed without contact. The team members were frustrated by their passive position as commentators and observers and by the limited opportunities to apply their varied skills to the detailed tasks. However, they were often able to take a more pro-active role, especially towards the end of the intervention, in identifying the need for a strategy to take the work forward beyond Carers Impact, helping their task force colleagues with the practicalities of drawing up and consulting on a framework. The rapport between the partners was generally good throughout and the task force group was able to identify real benefits from the involvement of Carers Impact. They were not aware that the level of this involvement had fallen short of the team's expectations.

Most of the Carers Impact partnerships between the teams and the task force groups conformed to this model. There were examples of teams in which one or two of the advisers were drawn into a more active collaboration while their colleagues remained on the margins. Another variant evolved in one fieldsite where the task force group proved unable to negotiate clear objectives and where most of the efforts of the team were necessarily confined to facilitation and background support.

The factors which confined the teams to a supporting role emerged clearly from the evaluation:

- continuing uncertainty about what the Carers Impact team could offer, collectively and individually
- a failure to negotiate a role for the team in the work plans around individual objectives or to schedule their involvement
- a poor fit (as perceived by the task force group) between the skills within the team and the specialist needs of the fieldsite. If the team was not seen as being able to offer a distinctive expertise, the task force group preferred to turn to their own networks for technical and professional advice
- an ambivalence on the part of the task force group about sharing ownership of the work with Carers Impact.

CASE EXAMPLE: FIELDSITE B

Two initial visits were made in quick succession in order to 'jump-start' the initiative in this fieldsite. A local decision had already been taken to focus upon promoting carer awareness through pilot schemes in two contrasting general practices, but progress had been slow. The intensive involvement of the Carers Impact team worked well in that it helped the local task force group to organise the pilot schemes around consistent methods and principles.

Less attention was given to defining the team's future contribution. Its role was seen in very general terms – generating ideas, problem-solving and keeping the task force group to the agenda – but no mechanisms or timetables were worked out for integrating the team into the work programme.

The result was that for most of the period of Carers Impact's involvement the energies of the fieldsite were devoted to the pilot site projects, and the team was detached from the development process. By maintaining a broad overview of the work and good relationships with the local key players, the team members were, however, able to offer a constructive challenge to the fieldsite on two fronts. The first was to improve practice in terms of carer involvement in the initiative. The second was to evolve a district-wide plan for raising carer awareness in primary health care teams, based upon the lessons of the pilot schemes. Through its facilitation of a conference with a strong carer presence, the team helped the task force group manage the transition from focused work in two localities to a broader development programme. A member of the task force group said:

> *'The Carers Impact team have always been readily available and willing to help and support us locally ... We used the expertise of the Carers Impact team to challenge our own thinking – occasionally we could be wrong!'*

Model 3: The fragmentary partnership

Uneasy coexistence would perhaps aptly describe the relationship between the adviser team and the task force group in three of the fieldsites where the early problems around the engagement of the team persisted for the entire span of its involvement. Rapport between the two parties was limited, and the team members were unable to negotiate a consistent role for themselves, either as facilitators or as activists. Little shared planning of the work took place,

rendering the team's involvement erratic and opportunistic. Small interventions were made but it was not possible for the team to shape the development process. Each encounter between the two parties tended to exacerbate their mutual frustration and bewilderment. Clearly, this was the least satisfactory or productive form of intervention. The main factors which impeded a more constructive partnership appeared to be:

- the devolution of the Carers Impact work within the fieldsite to a task force group which lacked power and leadership or whose leader lacked commitment to the initiative
- poor definition of objectives and tasks
- individual players within the fieldsite pursuing their own agency or personal agenda through the task force group, with little sense of cohesion
- an inability on the part of the team and the task force group to share their concerns over their failure to engage
- sometimes, poorly judged challenges set by the team, which heightened the sense of defensiveness within the task force group.

CASE EXAMPLE: FIELDSITE C

The early meetings between the Carers Impact team and the task force group in this fieldsite were tense and uncomfortable. The task force group felt it had inherited the Carers Impact brief from senior managers without adequate preparation. Rapid changes of chair within the group heightened the feelings of uncertainty. The group looked to the team to provide clear guidelines and options within which it could frame its development work. Instead, the team offered facilitation aimed at building the task force group into a more cohesive unit. Interpreting this as a refusal to deliver practical help, the task force group began to lose confidence in the team. Although the Carers Impact project staff worked hard to create opportunities for collaboration and the team offered help with specific tasks, there was no sense of a shared and planned exercise. At the end of the intervention, the task force group felt that Carers Impact had brought little added value to their own efforts. This view was supported by the team members, who believed that their marginal position had rendered them ineffective. A members of the task force group said:

> *'Advice from the consultants has been mainly confirmation of issues, facts, data, etc. which we were already aware of. A great deal of time was wasted on issues such as "the role of the team", rather than getting on with practical work.'*

What came out of the Carers Impact initiative in each fieldsite was critically influenced by the quality of the partnerships. Where the rapport was good, the team fully engaged and a sense of shared enthusiasm generated, Carers Impact demonstrated a considerable capacity for stimulating change. This rippled out from the task force group into the wider fieldsite, expressed both through tangible outputs and better processes for tackling carer issues. Where the partnerships remained focused on defining the role of the adviser team or where the task force groups continued to be divided by sectional interests, the energy of Carers Impact was confined and the gains were small.

THE CARERS IMPACT PARTNERSHIPS – KEY POINTS

- Three main forms of partnership evolved between Carers Impact adviser teams and local task force groups. These reflected different levels of involvement on the part of the teams.

- Fully committed partnerships were achieved when the adviser team and task force group were able to work together on the overall planning of the initiative and when each adviser became engaged in the work on detailed priorities.

- Many factors were associated with the building of fully committed partnerships, including positive leadership within the task force groups, an assertive style within the team and a good match between development priorities and the skills of individual advisers.

- A different form of partnership cast the adviser team in a supporting role, with team members commenting upon and facilitating the work of the task force group but with little close involvement in the action. This style of working together was less gratifying for the advisers but still produced benefits for the fieldsites.

- The fragmentary partnership was the least satisfying and productive. It reflected a serious failure to negotiate a role for the adviser team and an absence of personal rapport. The team made small interventions but had little impact upon the development process.

- The productivity of the Carers Impact intervention in each fieldsite was closely linked to the quality of the partnership.

Chapter 7

Changes achieved and not achieved

The evaluation of Carers Impact showed that change was achieved at a number of levels. Most obviously, specific pieces of development work emerged from the task force groups. There were also gains in carer involvement and in strategic planning for carer support. More generally, a higher profile for carer issues and improved collaboration between agencies were reported as spin-offs from the Carers Impact process.

These changes could perhaps be seen as building the fieldsites' capacity to tackle the central objective of bringing about change in mainstream support services. However, progress on this objective was disappointingly slight within the span of the Carers Impact intervention. Resource shifts towards carers were also small, and little was achieved in relation to a key objective of promoting special action to meet the needs of carers in the Black community.

Specific pieces of development work

There were tangible, direct outputs from the Carers Impact process – small projects or exercises undertaken by the local task force groups to address an aspect of carer support. The extent to which the advisers were involved in delivering these outputs depended upon the nature of their partnership with the task force group: where rapport was good and a flexible method of working together established, they assumed an active developmental role; where the relationship was less established, they remained rather more in the background, commenting upon progress and offering encouragement.

The outputs from Carers Impact could be divided into two broad types:

- *those which promoted carer access to services.* These included information packs and directories, a carer emergency card, and carer newsletters and helplines. Their function was to provide signposts to sources of help
- *those which aimed to increase carer awareness.* These formed a major strand of the Carers Impact work. In most cases they were targeted at service professionals. Examples were carer awareness training packages (in some cases involving carers as co-trainers); pilot projects in general practices to promote the identification and support of carers; a

general practice flowchart indicating the local resources available; and support for trainers in statutory organisations. There were also more public initiatives, such as 'carers weeks', which were designed to help people identify themselves as carers.

Many of these projects were very small in scale but they had a value over and above their immediate impact by demonstrating new approaches to old problems. For example, a carer emergency card developed in one fieldsite offered a practical method of co-ordinating the responses of several agencies to a crisis. Through the Carers Impact network events, other areas became interested in the model, some adapting it to their own needs. Another issue which struck a common chord was the promotion of carer awareness in primary health care teams. This was a focus for action within several task force groups, each one approaching the problem from a slightly different angle. Once again, the Carers Impact network facilitated the exchange of ideas and learning between fieldsites.

Many projects improved the repertoire of local support. They also demonstrated that Carers Impact was committed to real, practical benefits for carers. Thus they increased the credibility of the local initiatives. On the other hand, the task force groups proved highly susceptible to the risk of immersing themselves in the detail of small-scale work and losing sight of the more challenging objective of changing mainstream services. There were certainly examples of groups taking on projects (notably, the development of information materials) which were straightforward and could have been accomplished without external help.

A more strategic approach to carer support

Strategic frameworks for carer support were developed in several fieldsites. In one area the need for a strategy had been identified by the local task force group at the outset. Elsewhere, the Carers Impact teams had urged their task force group colleagues to develop a strategic approach to planning carer support beyond the lifetime of the Carers Impact initiative. The strategies typically included priorities for action, with accompanying costings and timetables. Responsibility for particular areas of the plan was also firmly located. In this way a commitment was made to sustaining the momentum initiated by Carers Impact.

There were some innovative approaches to producing a strategy. The district health authority in one area had been accustomed to producing glossy strategies for token consultation. In developing a carer strategy, the local task force group decided to produce an outline document to present to carer groups for their views. Carers were also involved in running workshops for service managers and fieldworkers to refine the content. The result was a strategy which was

owned by the key interest groups, including carers, one of whom said, 'This belongs to me; it's got my words in it.' The health authority subsequently considered revising its own approach to consultation along similar lines.

A higher profile for carers within the fieldsite

It was widely reported during the evaluation that the presence of Carers Impact had focused attention upon carers in the local arena and that their needs had been given higher priority as a result. Sometimes this had come about as a result of the awareness-raising exercises referred to above but there was also a 'halo' effect which derived from Carers Impact's status as a national project. In the absence of precise measures of attitude change, it is necessary to depend mainly upon anecdotal evidence. However, there were some firmer indicators which supported people's impressions.

Some examples, drawn from a range of fieldsites, are:

- more carer projects funded through Joint Finance and STG monies despite an increasingly competitive funding environment
- an increased level of referrals to carer organisations by general practitioners who had participated in an awareness-raising exercise
- improved procedures for identifying carers within primary health care teams, including computer programmes to 'flag up' carers
- new forms of consultation with carers, which extended beyond the Carers Impact process
- a marked trend towards the development of policies that gave explicit recognition to carers.

Efforts to improve awareness of carers were not new but by pooling the resources of different agencies Carers Impact was able to magnify their effect.

Improvements in carer involvement

This has been discussed at some length in Chapter 5 above. To summarise, the principal gains were that Carers Impact encouraged the fieldsites to experiment with new styles of consultation and to demonstrate the advantages of a constructive engagement with carers. Nonetheless, the level of direct carer involvement in the task force groups remained low, mirroring the problems which had beset carer participation in the planning process. The evaluation supported evidence from other developments within the fieldsite that strong,

independent, representative structures for carers are needed to support consistent and effective participation in formal structures.

Improvements in collaboration on behalf of carers

This was a particularly clear and positive outcome. Even those task force groups which were sceptical about the value of the teams' input recognised that the project had acted as a catalyst for collaboration on behalf of carers, reinforcing the more general pressures towards collaboration associated with community care planning. In the considerable majority of fieldsites the task force group was the first multi-agency forum organised around carer issues.

The experience of working in a collaborative rather than a competitive arena was particularly productive for health and social services personnel; there was some anecdotal evidence that this had improved relationships beyond the Carers Impact process, resulting in a greater willingness to share scarce resources for the benefit of carers. It was regrettable that the limited range of statutory agencies involved in the task force groups prevented these benefits from being spread more widely.

At a micro level, there were several examples of improvements in collaboration on behalf of carers within primary health care teams as a result of focused interventions. The result was that responsibility for supporting carers was more evenly shared and that there was more efficient networking with other local sources of help. Better working links between frontline staff were created, complementing the improved collaboration among purchasers and planners within the task force groups.

Resource shifts towards carers

Resource shifts attributable directly to Carers Impact were slight, consisting mainly of small injections of cash to support specific pieces of development work. However, it was suggested in several fieldsites that the presence of Carers Impact had pushed carers further up the agenda of local funders and had therefore helped indirectly to divert resources in their direction.

Special action to meet the needs of ethnic minority carers

Only one of the fieldsites focused on the needs of ethnic minority carers as a core issue. Elsewhere it proved difficult to engage the fieldsites in the Carers Impact agenda of promoting special action to meet the needs of Black carers. In many of the rural areas covered by the

project the minority ethnic populations were small and scattered, hardly impinging upon the main service organisations. Even in the urban areas where there were more clearly identifiable communities, ethnic minority carers seemed to be disconnected from the networks of carer organisations and groups, and the links needed to support focused development work did not exist.

In the one fieldsite which chose to specialise in this area, some imaginative work had already been undertaken by Black community development workers to create a forum for Black carers. However, the difficulties experienced in making direct links between the forum and the Carers Impact developments were a major impediment to progress.

Positive outcomes for carers through improvements in mainstream services

Although this was the central objective for Carers Impact, it was the one which proved most difficult to evaluate. That Carers Impact brought about minimal change to mainstream services within its own lifetime is abundantly clear. Thus far it failed. However, when the scale of the task of changing complex organisations and services is considered, and compared to the resources and time available through Carers Impact, the failure is hardly surprising.

It is therefore necessary to take a wider view and to ask whether Carers Impact created a climate within which improvements in mainstream services to carers were more likely to take place. Carers Impact informally adopted the motto, 'Think big, act small'. But were the small things that were achieved related to more significant ends?

The time frame for the evaluation was too narrow to permit more than an informed guess on this question. It does seem, however, that most of the small projects emanating from the Carers Impact partnerships, although valuable in their own right and an important practical demonstration to carers of a commitment to their interests, were peripheral to the big issues of service change. The main potential for meaningful improvement was through the development of strategic frameworks incorporating clear development objectives, well-defined responsibilities and realistic deadlines. As already noted, such frameworks were achieved in several fieldsites and were underpinned by improved collaboration and carer awareness.

It is possible that the Carers Impact project would have achieved more if it had been rather firmer about sticking to its main agenda and less compliant about being diverted towards intermediate goals. However, its style was to enable and persuade rather than to take an

uncompromising lead. The difficulties of achieving consensus among competing interests were much greater than had been anticipated, and the temptation to follow the line of least resistance and support those objectives which everyone could agree upon was sometimes overwhelming. Nonetheless, the Carers Impact project has learned important lessons from its own development programme and has committed itself to a more contractual approach to achieving mainstream service change in its second phase.

CHANGES ACHIEVED AND NOT ACHIEVED – KEY POINTS

- Many tangible, direct outputs resulted from the Carers Impact interventions. These had two broad purposes: to improve carer access to services and to promote carer awareness among service professionals.
- These outputs often demonstrated new approaches to old problems. Their value was increased by dissemination through the Carers Impact national network.
- Several fieldsites developed a more strategic approach to organising carer support.
- There was evidence of greater carer awareness within the fieldsites as a result of Carers Impact. This was reflected in service policies, professional procedures and the funding directed towards carer projects.
- Carers Impact stimulated new approaches to carer involvement and consultation, demonstrating to service agencies the benefits of partnership with carers.
- Improved collaboration on behalf of carers was a particularly clear and positive outcome of Carers Impact.
- Resource shifts towards carers which could be directly attributed to Carers Impact were very slight.
- Carers Impact largely failed to engage the fieldsites in its agenda of promoting special action to meet the needs of ethnic minority carers.
- It was difficult to identify positive outcomes for carers through improvements in mainstream services; however, Carers Impact did initiate cultural changes and more strategic approaches to planning carer support which may yield long-term benefits.

Chapter 8

The Carers Impact model

This final chapter draws together evidence from earlier sections of the report in order to appraise the effectiveness of the Carers Impact model as a development tool. Its strengths and weaknesses are considered in turn.

Strengths

The greatest strength of Carers Impact was that it acted as a catalyst for local action. It provided an opportunity, amidst the turmoil of competing pressures and demands, for fieldsites to clear some space for carer issues and to work to improve carer support. The external and independent status of the teams, their uncompromising focus upon carer issues and their link to a national initiative all helped to harness local energies on behalf of carers.

Carers Impact adhered firmly to the principle that carers' needs must be addressed through a multi-agency approach. This paid dividends in the creation of new partnerships within the fieldsites. Joint working groups were assembled, often for the first time, to define a common agenda in relation to carers. Although the range of agencies involved was limited and the involvement of the voluntary sector often peripheral, the forging of alliances between health and social services marked an important step forward in local joint action. In many cases, the Carers Impact teams helped to nurture and consolidate developing relationships, mediating between different interest groups in order to create common ground.

Another key principle which underpinned the Carers Impact model was the importance of carers being involved in the planning of services. The inclusion of a carer within each adviser team on an equal footing with professional colleagues emphasised this commitment and thus had a symbolic as well as a practical value. As this report has shown, the gains in real carer involvement within the fieldsites were uncertain but, at minimum, Carers Impact set a standard to be aspired to and encouraged a more varied approach to carer consultation.

As well as acting as a stimulus for action at the beginning, the teams were important in sustaining the task force groups' momentum and commitment over the period of the intervention. They did this by offering recognition and encouragement, by keeping the groups

focused on the task and, occasionally, by intervening to unscramble problems which were blocking progress. The position of the team as an external point of reference continued to be important.

In general, the sharing of skills and knowledge was a much less significant contribution than had been anticipated but there were instances where team members became involved in detailed tasks, sharing their own ideas and providing links with other sources of help.

Carers Impact's commitment to a strategic approach to carer support was an important influence upon the development process. Although it was not possible to rescue all task force groups from a preoccupation with the minutiae of small-scale developments, the teams did, in a number of fieldsites, help to pull these together within a framework which could provide a sensible basis for the planning of carer support beyond the lifespan of Carers Impact. In a few areas, the development of a carers strategy was a central strand of the initiative, and the teams were able to offer advice both about the content and about how to manage its presentation to senior managers and elected members.

The support provided for the adviser teams by the Carers Impact project staff was consistently sympathetic and positive, and administrative back-up excellent, although resources were at times severely taxed by the large number of fieldsites in operation. The decision taken by the staff to divide the fieldsites between them worked well in focusing their own energies and also in providing a consistent link for the teams. The presence of a staff member during the initial visits to the fieldsites was considered essential by the teams in helping them to negotiate the difficult entry phase.

Carers Impact brought added value to the work of the individual fieldsites by linking them together through workshops and conferences. This networking function was important to the fieldsites and, in some cases, marked a turning point in their own development process. Hearing about others' approaches to similar problems was a source of encouragement and of fruitful ideas. There was a strong desire for simple, practical models of carer support which could be adapted to local circumstances. This was something which Carers Impact itself had perhaps underestimated and had certainly played down in relation to the work of the teams, tending to dismiss the value of 'off-the-peg' solutions. In fact, the exchange of practical ideas through the network events was a notable source of creativity within the programme.

The Carers Impact model was a dynamic one. There was a commitment to learning lessons from each phase of the fieldwork and feeding these into the further development of the

programme. The network events helped to share the learning among the fieldsites and, at a later stage, the evaluation also played a part in identifying successes and failures. The difficulties and complexities of the development process could not have been revealed without an honest and open approach on the part of the project staff.

Weaknesses

The principal weakness of Carers Impact was its poorly developed entry strategy for the work in the fieldsites. The model depended upon the local task force groups being able to determine the agenda. When it was discovered that the groups were not sufficiently coherent to do this, the teams had no fall-back position and no agreed means of getting a grip on the process. Their briefing emphasised their responsive role but, too often, they found very little to respond to. Mutual bewilderment was frequently the result, wasting time and eroding trust.

A major question which hangs over the engagement of Carers Impact in the fieldsites is whether the chosen starting point was indeed the correct one. Although Carers Impact's central commitment was to producing changes in mainstream services, there was a failure to embrace a service change agenda at the outset. This was partly because the promised involvement of senior management tended not to persist beyond the initial negotiations, but there was perhaps a more fundamental problem.

The model depended upon being able to create a harmony of interests among the key players from which agreed action could evolve. But without the drive of top-level commitment to service change, the action programmes sometimes became overloaded with innocuous activities which reflected the lowest common denominator of agreement. An alternative point of entry might have been to consult local carers about their priorities for service change (thus putting them at the centre of the development process), to agree a focus with senior management and then to build the multi-agency support.

Leaving this issue aside and returning to the existing model, there was an evident need among the local task force groups for independent facilitation at the outset in order for them to achieve a shared focus and to identify priorities for action. However, the Carers Impact teams were not well adapted to providing this input. This was partly because the relevant skills were scarce within the pool of advisers but, more importantly, because a team of four people was simply too unwieldy for the task. The evaluation revealed considerable popular support for the idea of involving a single external facilitator at the outset and then drawing in other advisers with appropriate skills as the work progressed.

This relates to another query about the model concerning the selection of advisers for the fieldsites. Despite the commitment to being responsive to local requirements, Carers Impact was prescriptive in assembling the teams. There was no scope for the fieldsites to play a part in the selection process, which, as a result, depended upon an intuitive matching by the project staff. Inevitably, this was an inexact procedure. In some areas it worked extremely well but other fieldsites did consider that the teams had been imposed upon them and questioned the relevance of the advisers' skills. This was particularly an issue where the fieldsite had decided to focus upon a specialist area, such as caring for severely disabled children, where an in-depth knowledge of services for children across the sectors was seen to be desirable. If the advisers were not able to demonstrate that they had something additional to offer, the task force groups tended to rely on the expertise available within their own membership.

The evaluation raised a series of questions about the need for greater tightness and formality in the agreements reached between Carers Impact and the fieldsites. The model was predicated upon responsiveness and flexibility as core values. The notion of tying down the fieldsites to written contracts or timetabled interventions did not fit comfortably with this approach. Nonetheless, the realities of the work suggested that a firmer framework for the Carers Impact interventions would have maximised the benefits and promoted a more economical use of resources.

More formal agreements were needed at two points in the Carers Impact process – at the conclusion of the initial negotiations surrounding the application and at the point of the setting of detailed objectives by the task force groups. A general difficulty with the development process was the rapid erosion of senior management involvement beyond the initial stages. If this involvement had been built into a written agreement as a condition, Carers Impact would have been in a stronger position to challenge management withdrawal. A broad commitment to service change would have been another useful component of a formal agreement, providing a reference point for the work of the task force groups. It must be acknowledged, however, that Carers Impact was competing for attention within a crowded community care agenda. The imposition of stronger requirements on participants might have drastically reduced the number of fieldsites willing to be involved.

Carers Impact had intended that a formal statement of specific objectives and tasks would be negotiated with the local task force groups at some point in the development process. In practice this did not happen, mainly because of the difficulties which surrounded the entry phase. Informal understandings worked well in some fieldsites but in others it was difficult to keep agreed objectives firmly in sight, particularly where there was a frequent turnover of task

force members. Once again, a formal agreement might have been helpful in keeping the work on course.

The timetabling of the Carers Impact process raised rather different issues. Because of the assumption that the fieldsites would drive the work, there was a reluctance among project staff (and this was certainly shared by many advisers and task force group members) to constrain the development within an organised schedule of Carers Impact team visits. It would be better, it was argued, to work at the pace of the fieldsites and respond to their requests for help. In practice, the pace of the fieldsites was extremely slow, particularly in the early months, while the time frame for Carers Impact's involvement was narrow. The confusion which surrounded the entry of the adviser teams in most fieldsites often led to a situation of drift, with long gaps between team visits. Although the project staff kept in touch through their task force group contacts, the team members had no means of direct communication and began to lose a sense of momentum and involvement. On balance, the evaluation suggested that a more planned approach to the teams' involvement would have been beneficial to both the teams and the fieldsites.

There were some specific weaknesses in the operation of the adviser teams. Despite careful support from the project staff, it proved difficult for the teams to function as cohesive units. Long gaps between visits, limited time for planning and feedback before and after visits, and the geographical distance between team members were all contributory factors. As the programme unfolded, the project staff arranged more off-site team meetings; these were valuable but regular contact was needed to promote a planned approach to the work. This became a pressing issue when the teams divided into pairs and visited the fieldsite independently. Consideration was given to setting up a tele-conferencing facility so that the teams could hold regular discussions. This did not come about but might well have proved a reasonable and economic solution to the problems of communication and planning.

The lack of systematic reporting arrangements for the teams was a serious hindrance to good communication. At the outset the team members had been asked to keep 'reflective diaries'. But without a link to any formal feedback procedures, the amount and quality of information recorded depended entirely upon the motivation of each individual. Some people kept copious notes; others admitted that they had abandoned the attempt to keep up a diary. Informal verbal and written feedback between team members and Carers Impact project staff was often good but again depended largely upon the individuals concerned. Without an agreed format and reporting requirements, it was difficult to evaluate the information coming out of the fieldwork and use it in the further development of the programme. Communication between

team members was a more serious problem. Written notes of visits were circulated on an ad hoc basis but this information was not organised in a way that facilitated planning. A simple reporting form recording the purpose of each visit, the progress achieved and the action implications would have strengthened communication and helped to focus the teams' work.

The distance of team members from the fieldsites affected their pattern of work in quite significant ways. Given that the overall number of team days was limited for any one site, it was important to be able to use that time flexibly (for example, by drawing team members into specific meetings). Those who lived at a considerable distance from the site were not able to commit themselves for any less than one full day and were thus unable to accommodate a more flexible approach. As a result, they often became less involved than colleagues who were better positioned.

In considering the weaknesses of the Carers Impact model, it is important to remember that the time scale for the programme and the large number of fieldsites placed enormous pressures on a small core staff team. In retrospect, it would have been better to have tackled a smaller number of fieldsites over a longer period. This would have allowed energies to be concentrated on planning the development process, and many of the problems which arose within the programme might have been ironed out. A longer time scale would also have provided a more realistic basis for measuring the changes achieved.

The Carers Impact model – Key points

Strengths

- Carers Impact's greatest strength was that it provided a catalyst for local action on carer support.
- Carers Impact's insistence on a multi-agency approach significantly improved collaboration within the fieldsites.
- A commitment to carer involvement was expressed in the composition of the Carers Impact adviser teams, and this set a standard for the fieldsites.
- The Carers Impact teams acted as an external point of reference for the local development process, providing their fieldsite partners with recognition and encouragement, keeping them focused on their task and maintaining the momentum.

THE CARERS IMPACT MODEL – KEY POINTS (*cont.*)

- Carers Impact's commitment to a strategic approach to developing carer support helped the local task force groups to sustain a wider vision.

- Carers Impact brought added value to the work of the individual fieldsites by linking them together through workshops and conferences.

- The Carers Impact model was dynamic. There was a determination to learn from the fieldwork and to feed this learning into the further development of the programme.

Weaknesses

- Carers Impact's principal weakness was its poorly developed entry strategy. The teams were not designed to provide the facilitation which the local task force groups needed.

- The fieldsites played no part in the selection of team members; as a result, the skills and knowledge available within the teams were not always well adapted to local requirements.

- The looseness and informality of the agreements between Carers Impact and the fieldsites undermined clarity and well-focused action.

- A reluctance to plan the team visits in advance and agree a timetable with the fieldsites often led to long gaps between visits and a loss of momentum.

- Lack of contact and communication between visits made it difficult for the teams to function as cohesive units.

- Communication problems were exacerbated by the lack of systematic reporting requirements for the fieldwork. Planning suffered as a result.

- Some team members lived too far from their fieldsite to be able to work flexibly alongside the local task force group.

- The Carers Impact programme as a whole suffered from an overambitious spread of fieldsites and a narrow time frame for accomplishing change.

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54001000645625

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