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THE JOINT SOCIAL INFORMATION UNIT

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An Inter-organisational Approach to the Provision of Information for the Health and Social Services

Report of a King's Fund College Discussion Group

by

Muriel Brown BA PhD
lecturer, Department of Social Work and Administration,
University of Bristol

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King's Fund Centre
24 Nutford Place
London W1H 6AN

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1 SUMMARY OF CONCLUSIONS AND PROPOSALS

Having thoroughly endorsed the validity of an inter-organisational approach to social need and social provision, the group considered practical ways of developing it. The proposals for health and social services collaboration were given a cautious welcome, with reservations about the level of operational coordination. As a first step towards wider social planning, the group suggested that opportunity be found in the proposed formation of joint consultative committees under the new National Health Service legislation to set up joint social information units. Such units, which might be experimental at first, would operate on an area or county basis amassing information on the needs and resources of their areas and operating social planning models designed to illustrate the effects of possible actions or development across the range of provisions. Their main function would be to provide a clearly understood base of information on which those who make policy decisions could act. They would provide an overview so that different services could be made aware of the impact of their operation on the total pattern of need and an effective balance of professional interests be achieved on the service of the whole community.

2 ORIGIN AND MEMBERSHIP OF THE DISCUSSION GROUP

The inter-organisational discussion group was convened by the King's Fund College, primarily to explore relationships between the National Health Service and other social services. The idea for such a group derived to some extent from the integration courses which the college had run to promote discussion of the proposed NHS reorganisation. In these courses, it had become increasingly apparent that there was a need for contact between different social services as well as for the integration of the separate branches of the health services. The idea also reflected an upsurge of interest in social services organisation which followed the major administrative changes brought about by the 1970 Local Authority Social Services Act and which was stimulated by the impending reorganisation of the whole local government structure.

The discussion group consisted largely of chief officers from the health service and from local government. The health services representatives included personnel from regional hospital boards, hospital management committees, a teaching hospital, an executive council and the Royal College of General Practitioners. Medical, nursing and administrative staff were represented but not appointed members. From local government there was a chief executive officer, a medical officer of health, and directors of education, social services, housing and town planning. One group member came from the Department of Health and Social Security, and in addition to several members of the King's Fund staff there were two members of the staff of the London School of Economics.

The total membership was 24 and approximately 15 members attended each session. After an opening session of afternoon and evening the group met fortnightly for evening sessions only. There were eight meetings in all.

3 OBJECTIVES

The group began by examining some of the implications of NHS reorganisation and then proceeded by looking broadly at the need for social planning. This typified the express aim of the group, to combine discussion of practical issues with consideration of underlying principles and broad concepts. At the first meeting the main objectives of the group were spelt out.

1 To open up discussion of problems between representatives of different groups and agencies and promote an interchange of knowledge and ideas

2 to attempt to produce a model of a social planning group, crossing administrative boundaries

3 to provide 'missionaries', that is, people who could introduce concepts of social planning and an inter-organisational approach to their departments and agencies

4 PROCEEDINGS

In order to fulfil these objectives the group proceeded, in the light of the opening discussions on NHS reorganisation and the general need for social planning, to examine in some depth the needs of four patient or client groups in the population, in order to consider what they revealed of the need and potential for an inter-organisational approach to social services provision. The groups selected for this examination were

the elderly
the physically handicapped
the mentally ill and handicapped
the mother and pre-school child

The sessions were introduced and chaired by different members of the group. An attempt was made to set out the range and size of the problems presented and the extent of social service provision made, and then to consider the specific ways in which more effective provision presupposed some degree of coordinated effort between the different agencies and skills involved.

Further discussions were held on the idea of patient service or health care groups, as outlined in the NHS reorganisation plans, and on the initial findings of the Working Party on collaboration. The final session attempted to summarise the group's discussions and consider whether they had produced any guidelines for further action.

5 CONTEXT OF THE DISCUSSIONS

The group met at a time when NHS reorganisation was under active consideration, and several members were on the Government working parties which had been established to examine management within the reorganised service and collaboration between health and other social services. Most members were in some way personally and directly involved in NHS reorganisation and so they had the practical implications of this very much on their minds. The imminence of local government reorganisation was likewise of some concern, but of much less immediate relevance since the local authority members of the group were all from London boroughs and not directly involved in the changes.

On the social planning side, the group met at a time when awareness of the importance of this was emerging but the idea was still regarded with some suspicion and there was considerable confusion over terminology. Planning was, accordingly, defined for purposes of the discussion in two modes.

Simple planning was stated to be making adequate preparations to ensure that a known need for a defined service was met fully and on time. For example, that the need for maternity beds or places in primary schools was worked out on a reasonably informed and rational basis and plans got underway to provide them. Clearly even this simple planning calls for an ability to define and measure need before plans can be made or resources found to meet it.

Complex planning was defined basically as the addition of an awareness of the inter-relationship of needs and of services and the coordination of preparations for provision. For example, in meeting the need for care of the elderly or the mentally handicapped, it was essential to understand that the level of provision in one service would affect the need for another service, so provision should be planned together to avoid overlapping or gaps.

Amongst the reasons why social planning was currently arousing interest the following were regarded as most significant. The sheer size and scope of the social services sector, its rate of growth and its rising costs all serve to increase the demand to rationalise it. Despite the growing use of costly resources there is continued evidence of inadequacy in some provisions: waiting lists and staff shortages are common, while massive problems in housing and education, for example, remain barely touched upon. There is more and more widespread awareness of the subtlety and complexity of human need which calls for a holistic view of problems, but at the same time a growing necessity for specialisation and a trend towards greater professionalism militate against easy inter-agency cooperation. And finally, a major factor in the concern for social planning is the adoption within many services, of policies of prevention. The current attempts to prevent and forestall child neglect, ill health, delinquency, family breakdown, the institutionalisation of the mentally ill, or the social isolation of the elderly, are all policies which necessitate a breakdown of narrow administrative boundaries and a clear will to act and plan in an inter-organisational manner.

6 FINDINGS OF DISCUSSIONS ON CLIENT - GROUPS

The group produced ample evidence of the need to consider services in relation to one another and to plan provision as a whole. For example, in the first discussions on the elderly as a patient or client group, it was noted that several bodies were vitally concerned with their welfare. The DHSS was concerned very fundamentally with the direct provision of retirement pensions and supplementary benefits and, indirectly, with direction of medical care and personal social services. The aged were a major patient group within the health service but they were also one of the major concerns of the local authority personal social services, especially in the provision of residential care, while local authority housing was increasingly concerned with special accommodation for old people. Moreover, in addition to statutory concern, a wide range of voluntary effort was engaged in old people's welfare. It was not only important that those who provided one service should know of the existence of other relevant services - though that was vital if overall provision was to meet the varied needs of the elderly and do so smoothly without the individual recipients of services feeling themselves to be fragmented - it was also important that services were planned and developed in relation to one another. It was noted that demand for a service was in certain circumstances transferable to another service. For example, demand for places in local authority homes could be affected by the availability or otherwise of sheltered housing units. It was important not to plan provision of the one without reference to the other. There was no absolute need for most services - need was relative to the provision available and to public knowledge of it.

This point about the substitutability of demand was made again in relation to other groups, notably the mentally ill and handicapped. It led to a further important observation, that in any joint planning venture that was undertaken, an

attempt must be made to get the total picture of need. It was no use just planning for one group, however comprehensively that was tackled. It was necessary to know the needs of the total community so that there could be flexibility in the use of provisions. Only in this way could services be operated efficiently and prevention of distress become possible. In all the 'need group' discussions, the necessity for active inter-relationships between services was made increasingly clear. One could not discuss the health care of the mother and child without considering the question of education; the needs of the younger disabled were as much for training and employment as for welfare services; understanding of the situation of the mentally ill and handicapped in our society required a grasp, not only of service provision, but also of the general economic, social and cultural conditions which helped determine society's perception of the problems.

7 COLLABORATION

It was clear that social planning, in the sense of a comprehensive approach to the provision of services to meet need rather than a traditionally fragmented approach by the different services such as health, education and personal care, was highly desirable. It was equally clear from the discussion that it seemed, at this stage, hardly practicable to hope for comprehensive planning. The practical context of the discussions already noted - impending reorganisation of the NHS - tended to focus attention on the need of the health service to cooperate with other services and not on any abstract need for planning. It was accepted that it was most appropriate for the group to concentrate on collaboration between area health authorities and the local authorities. This decision was clearly a reflection of the long heritage of administrative functionalism in British social services - the provision of a service according to the kinds of skills available rather than according to the needs of the persons receiving services. This had meant that we have grown used to the development not only of professions but of administative units grouped around professional skills - hence the development of health services, education services and such like rather than the provision of services for the disabled, the under-fives, or the elderly. This approach has much to commend it, allowing as it does for the advancement of professional expertise, but it can be inefficient, especially where services begin to seek to prevent rather than cure pathological conditions. It can lead to overlapping of provision, the ignoring of certain aspects of need, or the continued provision of a service that no longer fits a changing pattern of need, to the point of real neglect of new needs. It can also alienate the very people who need services by making them feel that they are merely the recipients of different kinds of professional expertise and are not regarded as significant individuals.

Recognition of the shortcomings of a functional division of services has led to current anxiety to bridge the gaps between different organisations and professions. In examining collaboration, the group found many practical problems, but these did not appear wholly insurmountable, unlike those facing planning on a large, comprehensive scale.

The major problem of collaboration was that made explicit by the question: At what level should collaboration take place? In terms of the immediate practical issue of health and local government collaboration it was obvious that the area health authority and the local authority would have discrepancies in both area and responsibility and it would not be easy to match them. Moreover the local authorities were already developing corporate management approaches to bridge gaps between services, to decide competing priorities more fairly and to attempt to consider the total picture before planning their provision. The great fear was that, if collaboration was formalised at a high level, it would become unreal. Joint planning had to be really operational. It needed to be concerned with actual provisions not merely abstractions. This meant it had to lie with those actually responsible for getting things done.

The group's anxieties were not allayed by the Working Party's recommendations for collaboration since these have so far failed to meet the last point. It was considered that many practical problems remained: in particular, the composition of the health care planning teams and their relationship with district management teams; the very real issue of how much time the actual providers would have for getting on with their own jobs if they were forever at meetings; the detailed problem of balance of influence in planning from the health side between clinicians and administrators; the issue of whether members could or should be involved in the realities of collaboration as planned by the arrangements for joint consultative committees.

8 A SOCIAL PLANNING MODEL?

Collaboration, though itself a laudable development, was not the same as social planning. The group was quite clear that a more general overview of social needs and provisions was desirable to avoid the inevitable professional blinkers which remain on inter-agency discussions and to enable a more objective assessment of social priorities to be made. But it was equally clear that it was not easy either to suggest how one could obtain such a view, or to decide how far such an assessment of priorities could or should be the ultimate determinant of policy decisions. Nevertheless, the group, despite its initial feeling that comprehensive social planning was impractical, became increasingly convinced of the need for it and determined to find some way of encouraging its development.

Existing social services operate with insufficient data, an inadequate analysis of relationships between services, amateurish decision-making processes, compartmentalised development plans and inflexibility in the use of scarce resources. If these criticisms are accepted as valid it becomes imperative that the services start to learn how to coordinate and rationalise their provisions and to accept a degree of social planning. The question then becomes one of deciding whether to develop a planning authority independent of existing functional services or a unit supported and utilised by them.

The group considered the suggestion of an independent social planning authority, but rejected the idea on grounds of principle as well as practice. Such an authority would have too much power divorced from responsibility. It would be planning divorced from execution and this would cause friction. It would be difficult to decide at what level - local, regional or national - such an authority should operate, how it could be reconciled with existing authorities, and how it could become part of the democratic process.

It therefore appeared to the group that it was better to pursue the idea of developing social planning amongst existing authorities, even if that necessarily involved some compromise over the range of provisions concerned. It was agreed that the prerequisite for meaningful planning was the establishment of autonomous units for intelligence purposes. It was also agreed that the 1974 reorganisation could properly provide an opportunity for experimentation with planning. Accordingly, the group evolved a proposal for the establishment of planning or intelligence units at area or county level serving the proposed joint consultative committees. They could take cognisance of a wide range of social and economic facts and trends and provide information to AHAs and local government. Since they would be without authority or executive power, such units could more properly be known as 'social information' rather than 'social planning units'. The group considered their staffing, role and functions and made the following proposals.

9 PROPOSALS FOR THE ESTABLISHMENT OF JOINT SOCIAL INFORMATION UNITS

The functions of such units would be

1 Collection of data on the area, and their analysis to reveal socio-economic trends (Most of the data would be obtainable from existing central or local authorities but some information would have to be obtained by research.)

2 Definition of need and its systematic measurement and assessment

3 Development of techniques for predicting changes in the pattern of need (that is, the determination of significant social indicators)

4 Construction of a social planning model utilising data on need and resources, so that the effects of any proposed changes in development or shifts in the pattern of need could be worked out rapidly on the model

5 Monitoring of services to determine the actual effect of provisions and policies

6 Provision of information from these activities in a manner intelligible to those involved in making decisions at all levels.

The role of the unit would be primarily to service existing authorities. Changes in policy must remain as political decisions, but the units could enable decisions to be made on the basis of informed assessments of their likely effects on the whole spectrum of need and service. The units could utilise consumer research techniques to improve knowledge of the recipients' rather than the professional view of services, and to help clarify the picture of community needs.

The units could cooperate on a regional or even a national basis to ensure maximum flow of information where a particular issue required assessment on a wider than area basis or where inter-area comparisons were desirable.

The staffing of the units would be by a combination of social scientists, including statisticians, and persons with practical experience of the provision of existing services or of new town or community development projects. The units could be linked to a central unit (such as the Centre for Environmental Studies), or to regional units based on universities, for advice and help on techniques of social analysis. It is anticipated that the resources for staffing 90 such units would not immediately be available but would have to be built up over time. Some units could be started on an experimental basis, however, to become operative from April 1974. Such experimental units might require funding by voluntary bodies initially.