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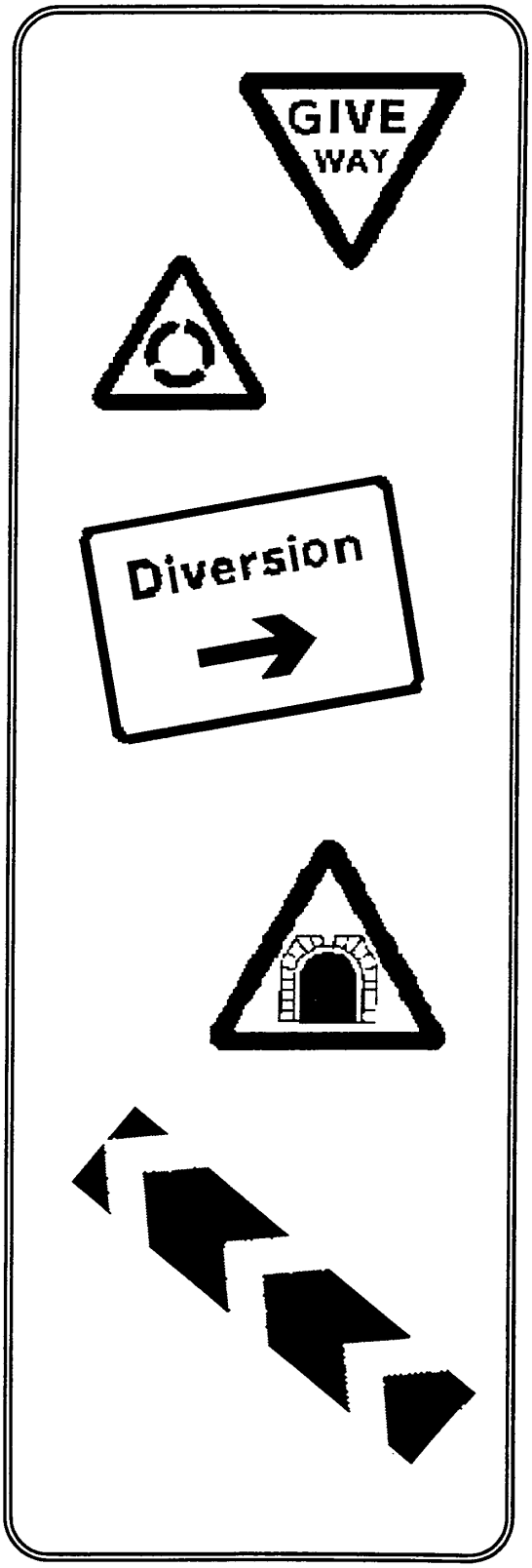
Community Care and the Prospects for Service Development



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Chapter 1

Introduction

During the period leading up to and following the introduction of the NHS and Community Care Act 1990, the organisation and operation of health and social care agencies have undergone some radical changes. These have been a direct result of reforms intended to achieve more efficient use of resources and more effective support for individuals with long-term care needs.

However, there has been little change in the services offered to ill or disabled people with long-term care needs or to their carers. Community care services have remained largely untouched by the implementation of the reforms, with the traditional menu of domiciliary, day and residential provision still prevailing and the much hoped-for improvements in practical support for carers not yet materialising.

The slow rate of development in community care services has led to some considerable dismay and disappointment both among service users and their carers, many of whom had welcomed the reforms as new opportunities for radical improvements in service delivery, and also among many managers and practitioners who have felt disappointed with – or at least perplexed by – the evident lack of progress made in developing services more in tune with the known needs and preferences of users and carers.

This lack of progress cannot be put down to lack of interest or effort in the task of developing better services. Many service development initiatives were mounted prior to and during the introduction of the reforms by national agencies (including central government) and local statutory and voluntary organisations. Development programmes designed to improve practical support for carers were perhaps especially prominent during this period, with several important charitable trusts and foundations investing in local projects and schemes up and down the country. The question therefore remains. Why have community care services failed to develop in ways intended by people who have recognised the need for improvements and who have actively sought to bring about change for the better?

This monograph attempts to answer that question. It does so by drawing on the experience of one particular service development initiative supported by the King's Fund, establishing connections between this local case study and the wider context of the community care reforms and their impact nationwide.

We argue that the organisational turbulence created by the reforms has had an adverse effect on service development. We also maintain that conventional models and methods of service development are ill-suited to such turbulent conditions, especially when organisations attempting to bring about service improvements are merged, closed down or re-created in new forms and the staff involved are frequently on the move, being redeployed or even having to look elsewhere for work. In these conditions, successful service development is made all the more difficult and will require, we believe, more focused approaches and more creative application of developmental methods or combinations of the same.

This monograph begins by looking at the recent past but moves very quickly into the present and, indeed, into the future. For, while we began with a desire to understand and explain problems which have arisen over the last few years, our analysis leads us to conclude that these same difficulties are likely to prevail in the immediate future. The organisational turbulence referred to earlier shows no signs of abating as new health commissions are created from old health authorities and family health service authorities, as new unitary local authorities are created from county authorities, and as the NHS moves towards becoming primary care-led. In the absence of greater stability, it continues to be important to find ways in which the community care service development agenda can be advanced without being deflected or stalled by the organisational changes taking place.

Our analysis and recommendations will be of interest to all those working in local authorities, the NHS and voluntary and private agencies who have a responsibility for developing community care services. They may be elected or appointed members, managers or designated development staff. Charitable Trusts and other funding bodies, including the Department of Health and the NHS Executive, may also be interested as the issues discussed have a bearing on how they may choose to stimulate and support service development in the future.

Chapter 2

The King's Fund Yorkshire Carers project – a case study

Background

In the late 1980s, the King's Fund mounted a national service development initiative aimed at improving practical support for carers. Building on earlier work, it determined that the greatest impact could be achieved by helping the statutory health and social services agencies to make services for carers part of their mainstream activities. Five projects were sponsored in all: three in local authorities, one in general practice, and one in a regional health authority (RHA), which has prompted this paper.

When the King's Fund selected Yorkshire RHA in 1991 as one of the sites for testing out new ways of improving practical support to carers, this offered an exciting opportunity to see what contribution an RHA could make to developing a more carer-sensitive environment in health and social services. It was known that, under the new arrangements for community care, local authorities would have a lead responsibility, but the NHS was also acknowledged to have an important contribution to make.

Furthermore, Yorkshire RHA had already developed a policy on carers (the only RHA in the country to have done so at the time) and was keen to keep that policy under review. The authority had a reputation for taking a lead in community care service development in the region at a time when other RHAs tended to be more cautious. It also had a good record of collaborative working with its social service counterparts, having mounted a number of joint initiatives with regional branches of the Social Services Inspectorate and the Association of Directors of Social Services.

The project had two objectives:

- to assist district health authorities in improving support for carers;
- to enable Yorkshire RHA to implement and review its policy guidance on carers.

Improving provision in the districts was to be achieved by inviting them to submit plans for development work which they wished to see in their localities. All districts were expected to involve local carers and social services departments in planning and implementing development initiatives and to focus their efforts on carers' support issues considered important in their local areas, such as the development of respite services, information and advice and care in the home.

It was assumed that, by putting forward project proposals, a district was showing commitment to bringing about change in the way it provided services to carers, by both identifying its priorities for action and registering a willingness to accept support from the region to move forward.

The response from the districts was greater than anticipated. Ten wished to participate in the initiative and eventually six were selected which seemed to offer a wide range of opportunities for developing and testing mechanisms for securing the project's overall objectives and priorities. It was agreed that each district would establish its own project management group and decide for itself how the agreed development would be pursued.

It had been made clear from the onset that the RHA and the King's Fund had no funds to contribute but that both would support the district endeavours. The main vehicle for providing that support was a project manager employed by the region who was responsible for convening and facilitating the working groups in the selected districts, arranging training and staff development and ensuring that activities were monitored and evaluated and lessons disseminated. A King's Fund development consultant worked with the project manager and provided a link with the King's Fund and other carers' development initiatives taking place across the country. The development consultant also participated in the work of an advisory group established by the RHA in which wider statutory, voluntary and carers' interests were represented.

At its inception, therefore, the project was addressing identified needs: namely, the development of practical support services for carers. It was broad in its interpretation of what those developments might actually amount to, expecting and encouraging experimentation. It was clear about process, i.e. appointment of a project manager, supported by consultancy and with a representative advisory group for reference purposes.

All of this adds up to a 'traditional' approach to service development. It is essentially a long-term commitment and process, which has the best chance of success in a relatively stable environment. However, the introduction of a 'market' approach to community care brought about a number of changes which critically weakened the stability required, and in a very short space of time, the Carers project experienced severe difficulties.

The role of the RHA

The position of the RHA changed in several respects during the lifetime of the project. The Priority Service Group of the RHA had originated the project and was given the task of sponsoring and managing it, but its own future quickly became uncertain. Management changes meant that the particular carers' project champion was acting up with additional and pressing responsibilities for trying to ensure the unit's survival. In fact, it was eventually contracted out to the Nuffield Institute, which is an organisation interested in combining the perspectives of both academic research and service development. The future of the RHA itself then came under close scrutiny as a result of the Government's intention to reduce the numbers of RHAs and the people working in them, and the future role of an RHA in service development began to look very unclear. The Yorkshire Region, towards the end of the project, was merged with the Northern Region.

The reorganisation of health care and social care

At the time the project was conceived in 1990, the Yorkshire Region covered 22 district health authorities and seven Social Services Departments. Following the implementation of the 1990 Act, the 22 health districts in the RHA were reduced to seven health authorities with responsibilities for commissioning health care, along with a number of provider units

delivering acute and community services. This meant that the organisations with which the RHA contracted to pursue service development had effectively ceased to exist quite early in the life of the project. Although (with one exception) the projects continued to follow the original objectives, it became difficult to know who to hold to account when problems emerged.

Some time later, social services departments were similarly obliged to introduce new arrangements for managing community care and were encouraged to separate their purchasing and providing activities. New ways had therefore to be found of relating to the different interests in health and social care, and while these were being developed, added confusion was created for those on the outside trying to influence those on the inside.

The purchaser-provider split raised some important questions about how change could be achieved. Before the changes, it was assumed that, if senior management in health or social services could be brought to see the strength of arguments for certain types of development, they would simply use their clout to make these happen. But an awareness that new structures were being developed led to questions about who was in control and how change could now be secured.

Would it be initiated through the commissioning side, which in social services had not really been identified and which in the health service was located in the newly appointed commissioning agencies, often quite small and unsure of their role? Or would it be found on the provider side? The providers were numerically bigger and often in control of information about needs, but were unsure about how the new commissioning agencies were going to behave towards them.

In Yorkshire, it was not clear at all who could bring change about or whether the systematic approach to service development initially assumed, was still possible. Although throughout the lifetime of the project there were useful developments, they seemed to be more the product of opportunism, the commitment of a particular manager, the use of unspent budgets or instructions from Government, than anything coherent and planned.

Changes in personnel

In addition to these organisational changes (and in most instances closely connected to them), both the King's Fund development consultant and the project manager changed three times, while almost all of the key contacts at the selected development sites changed at least once. Although some people find change stimulating and challenging, it can also lead to low morale among staff. Staff may become resistant to new thinking and understandably seek to safeguard their personal positions, rather than engage with the innovation which is central to service development.

On balance, the changes were a hindrance to development in Yorkshire. As people associated with the project left, they were not always replaced very quickly or sometimes at all, and champions were therefore lost; new people asked to assume roles in relation to the project did not always see it as a priority or did not really understand what it entailed; sometimes the role was given to someone who was not sufficiently well placed to have any influence; and towards the end of the project users and carers on the various advisory committees felt that they had participated in endless consultation to no effect.

Chapter 3

Changes in community care since April 1993

The broad concerns being expressed about the fate of the Yorkshire Carers project take on a wider significance if they are viewed as an early indication of the general impact of the health and community care reforms upon service development activities at a national level. This chapter looks at some of the early evidence of this impact. In doing so, it locates potential service development activity taking place at two levels:

- at the macro level through market management;
- at the micro level through care management.

It also considers developments taking place on the health and social care boundary of community care.

Service development at the macro level

The policy context within which markets in community services have been expected to develop does not bode well for traditional approaches to service development, mainly because of the inherent tensions within the strategy (PSSRU/Nuffield Institute, 1992; 1994; 1994a).

Local authorities have been required to manage a market which they did not create and which was considered to be financially out of control, as well as developing in ways considered to be at variance with the objectives of the White Paper, *Caring for People*. Even in April 1993, when local authorities finally assumed lead role for community care, three-fifths of elderly people in care homes were in the independent sector, as were 40 per cent of mentally ill people. Independent sector residential provision for people with learning difficulties had risen from 5,000 in 1987 to 13,000, while private nursing home beds had tripled.

Understandably, local authorities were often too preoccupied with the management of this inheritance to worry too much about the creation of a new non-institutional market, especially when it was expected that they would reduce their own in-house provision wherever possible. Moreover, not only was public sector provision expected to reduce, but so was the strongest sector of independent supply, the institutional sector. In place of this, an underdeveloped and unregulated supply of day, domiciliary and respite care was expected to emerge – a task requiring huge skills of market management and service development.

Alongside all of this, the NHS was increasingly redefining 'health care' in a more narrow way, and looking to local authorities to take over responsibility for continuing care. In such a context, it is unsurprising that service development problems were experienced. These can be placed in three broad categories:

- ideological problems;
- demand-related problems;
- supply-related problems.

Ideological problems

One of the early findings on managing the new market is the frequent opposition on the part of local authority members to the idea of involving commercial providers in social care, coupled with a fierce pride in existing public sector provision. This may not be simply an ideological stand, but could also reflect a more practical concern that, in the event of inadequate profits, private agencies may simply withdraw and leave the local authority to deal with the consequences. The strength of such feeling will vary between localities, and may often not get beyond the level of an unwritten political rule. It is also a position which can change over time.

The PSSRU/Nuffield research found a new pragmatism slowly replacing initial anti-commercialism in parts of England, whereas in Scotland there has been a bitter dispute between the Convention of Scottish Local Authorities and the Scottish Council for Independent Care over allegations of bias against the private sector. The obligation in England to spend 85 per cent of the Special Transitional Grant in the independent sector has forced local authorities to develop a relationship with the independent sector, but this has often resulted in the purchase of a service simply *because* it is in the independent sector, rather than because it is meeting a local need.

Demand-related problems

Mapping need is an activity which it is expected will take place at both the macro and micro levels, and can be regarded as the basis of service development – if needs are not properly understood, then services are likely to be inappropriate. However, it is not a straightforward exercise, for it should take into account latent and future needs, as well as current needs, and this has to be related to existing and potential supply. This task has not been effectively pursued in the past, yet it is now within the remit of small commissioning sections which may lack the broad skills and specialist knowledge which are required.

There is also still a strong tendency to equate need with inputs – the idea that what people 'need' is more services – rather than with the identification of desired outcomes in people's lives which can be expected to arise from a service intervention (Qureshi, Nocon and Thompson, 1994). And, although the *raison d'être* of commissioning is an improvement in the quality of life of service users and their carers, it is not yet clear how they have a stake in the commissioning process.

Supply-related problems

Even where demand-related problems are being tackled, difficulties remain with the supply side of service development, especially when commissioners are not free to use the sector of supply which seems best able to meet identified needs. The early experience in community care is that of a paucity of alternative providers of day, domiciliary and respite care coming from the independent sector. In the case of the commercial sector this arises from concerns about profitability and uncertainty about purchaser intentions, while in the case of the voluntary sector there is unease at the loss of independence implied by the shift to a contractual relationship with a commissioning local authority (Hudson, 1994).

Small providers can feel particularly threatened by the burden of transaction costs, which requires them to invest in staff recruitment, training and management and financial

accounting systems. The high administrative overheads of contract bidding can make small providers look uncompetitive when compared with the large corporate providers; yet, it may be precisely the small local organisations that are best placed to meet specialist user needs, particularly in the case of minority ethnic users. In the absence of competition, established providers will dominate the market, and this may not be in the best interests of users. Equally, there is an unresolved tension between competition and collaboration. A managed market requires collaboration across a range of professional and organisational boundaries, but simultaneously requires distance between purchasers and providers, as well as competition between providers.

Service development at the micro level

Care management was described by the Social Services Select Committee (1990) as 'the cornerstone of the Government's approach to improving the effectiveness and efficiency of community care services', and front-line care managers with access to budgets have a critical role to play as the 'eyes and ears' of the service development process. By 1 April 1993, all local authorities were expected to have instituted some version of care management. What do we know so far about the extent to which care managers have carried out a service development role which might counteract some of the negative forces identified in the Yorkshire Carers project?

Developing care plans

The aim of care planning is to identify the most appropriate ways of achieving objectives identified by an assessment of need. The early evidence points to two difficulties:

- failure to develop plans with a clear purpose;
- failure to use information systems.

Failure to develop plans with a clear purpose

An examination of practice in six authorities in 1993 by the SSI (Social Services Inspectorate, 1993) discovered a lack of clarity among some staff about the purpose of the care plan; while a parallel investigation by the DoH (Department of Health, 1993) concluded that, on the basis of written assessments and interviews with users, it was not always easy to identify why users with broadly similar needs and circumstances ended up with very different forms of support. Staff in all of the authorities visited were still experiencing difficulty in separating out the assessment of need from the negotiation of a care plan, and were strongly tempted to link specific needs to known service responses, without regard to any overall objective or consideration of possible alternative ways of achieving that objective.

Failure to use information systems

In centralised organisations, a few decision makers take key decisions, and the process is characterised by slowness, long chains of command and a culture of referring upwards. By contrast, a care management strategy involves a large range of decision makers spread over a wide geographical area, with an expectation that decisions will be made quickly and flexibly to meet individual need. Such an approach requires a comprehensive information strategy. Care managers will need to know what services they can get, from whom, how quickly, at what cost and with what quality. This in turn will require an IT strategy with equipment close to priority users.

There is little evidence to suggest that current information structures are capable of this. A DoH survey (Department of Health, 1994) found that a variety of computerised information systems was being developed in the sample authorities, but most were experiencing technical difficulties or were proving time-consuming to operate. In a separate survey in four authorities between October 1992 and May 1993. Hoyes *et al.* (1994) also found that fieldworkers lacked both knowledge of available options and a confidence in their own ability to manage devolved budgets.

Implementing care plans

The key implementation principle is to identify the most appropriate ways of achieving the stated objectives of the care plan with the minimum of intervention. As such, it lies at the heart of service development. It is at this stage that the problems of both macro and micro service development intersect. A survey of authorities conducted by the DoH (Department of Health, 1994) reported that the major frustration of practitioners at this stage was that of not having available a ready supply of domiciliary care options in the independent sector. And even where such options did exist, there was concern about verifying their quality.

Hoyes *et al.* (1994) felt that, in order for identified needs to be translated into service realities, more development work had to be undertaken at local level to encourage potential providers to offer services, but care managers were not thought to have the time or skills for such 'market making'. For their part, the aspect of planning that was repeatedly raised by independent sector providers was that they felt excluded from the strategic planning of services and were not being given much indication of authorities' purchasing intentions.

The general absence of options means that care managers are struggling to develop the much vaunted unique packages of care promised in *Caring for People* – indeed, in service development terms, the 'set menu' largely remains the order of the day. The explanation for this is that care manager discretion is being squeezed at both ends of the provider continuum. With independent providers, the 85 per cent rule has meant that most of the Special Transitional Grant has been used to continue funding placements in independent residential and nursing homes; while at the statutory end of the continuum, local authorities remain reluctant to expose their in-house provision to the effect of budget-holding care managers. Until care managers have greater control over budgets, it seem unlikely that they will be able to respond effectively to the varied individual needs of users, but, equally, they cannot be expected to 'make the market'.

It is also important to consider the impact of care plans upon carers as well as users. The evidence here also suggests that, for the most part, the community care reforms have not resulted in new and flexible forms of carer support. Two reports by the Carers National Association (Carers National Association, 1994; 1995) have expressed doubts about the beneficial effect of the changed system. The 1994 report consisted of a survey of 426 carers. It found that more than a quarter had not even heard of the changes a year after their introduction, and that fewer than one in seven could discern any improvement. The 1995 report covered a survey of more than 2000 carers, as well as a trawl of SSDs and a MORI poll. Three quarters of carers believed that the community care changes had made no difference to their lives or that services had actually deteriorated; up to a quarter said they were experiencing real hardship as a result of increased charges.

On the optimistic side, the new Carers' (Recognition & Services) Act will guarantee full-time carers a right to an assessment of their own needs, as well as those of the person they look after. However, there is no entitlement to have identified needs met, and it also needs to be noted that the 1995 CNA report found that 60 per cent of those carers who had already undergone a separate assessment, thought it made no difference to them. All of this suggests that the established evidence of carers as poor, in ill health, tired, frustrated and stressed (Scope, 1995) is unchanged, and that the need for carer service development initiatives remains as strong as ever.

Working across organisational and professional boundaries

Calls for enhanced collaborative activity lie at the heart of several concerns critical to the service development role of care management: a recognition that the boundaries between professionals, services and agencies militate against user-sensitive responses; the existence of overlap and duplication of service coverage; and a feeling that agencies may be pulling in different directions. These difficulties were fully acknowledged in the community care reforms, and care management has been given the ambitious remit of co-ordinating activity in respect of assessment, care planning and service development. However, it is already evident that care managers are having difficulty in delivering the 'seamless service', especially at the boundary between health care needs and social care needs.

The 1993 survey by the DoH reported that 'the striking impression of the early months is how limited the role of other agencies has been', and this remained the case in a survey of different localities a year later (Department of Health, 1994). In exploring the marginalised position of community health personnel in the community care reforms, the latter investigation came up with a range of explanations: that community health professionals saw themselves as providers not purchasers; that social care assessments did not figure in their contracts; that they had no formally recognised authority to co-ordinate health inputs; and that they regarded themselves as already overloaded.

This adds up to a formidable range of obstacles to inter-agency service development, but underlying it is the unresolved tension between the respective responsibilities of health and social services, and in particular a concern that community care is simply a low priority for the reformed NHS. Although health personnel account for 60 per cent of referrals for social care support, and notwithstanding that community care figured in the NHSME priority guidelines for 1993/4 and 1994/5, the 1993 DoH survey concluded that 'the overriding impression from this study is that community care rates poorly alongside the many other changes currently underway in the NHS'. Collaborative service development cannot flourish in such a climate.

Service development at the health–social care boundary

Much of the comment upon the community care reforms has understandably focused upon *Caring for People* and the role of the local authority as lead agent in the changes. However, service development activity has also been critically affected by changes taking place in the health service. The issue here is not so much the weakness of traditional or emerging collaborative mechanisms, but rather the ostensibly unplanned ways in which changes in the NHS have had an adverse impact on the service development agenda of local authorities. Wistow (1995) identifies the key issue as being the changes in the acute hospital sector and their implications for community support. Developments in pharmacology, medical technology

and minimal-access surgery have intersected with budgetary pressures to reduce lengths of stay, increase day surgery rates and enable more diagnosis, treatment and monitoring to take place outside the traditional hospital setting. The resultant unplanned blurring of the boundaries between secondary, primary and community care has not been conducive to a shared approach to service development between health, nursing and social care agencies and professionals.

The issue which has probably attracted most attention is that of responsibility for continuing care. Long before the publication of the White Paper in 1989, the NHS was taking full advantage of the social security subsidy to private nursing homes to reduce NHS convalescent and continuing care beds and simultaneously redefine the role of the acute sector as a location of limited availability. In effect, an understanding began to emerge that hospital care was allied to medical technology rather than nursing care, and that those who could conceivably be treated elsewhere should be prompted to do so.

Draft Guidance on continuing care in 1994 (NHSE, 1994) appeared to encourage the NHS to develop this line, but the critical reaction to these guidelines resulted in some softening of approach in the final guidance issued in 1995 (Department of Health, 1995a). Nevertheless, Wistow (1995) notes that this still leaves the extent of NHS responsibility for funding nursing care varying according to the location of the care, rather than the needs of the patient. The NHS remains responsible for funding the nursing care of people in residential homes, NHS hospitals and the community, and is not able to charge for this care. However, most nursing home care is expected to be bought by social services departments and users will be charged for it according to their means. This has given rise to a chaotic situation in which users, health care agencies and social care agencies all seek to develop strategies which will protect their financial interests, rather than promote high quality care. Service development is inherently unable to flourish in such a scenario.

The proposed shift from a secondary to a primary-led system of health care is bound to create further uncertainty. The last decade has seen more attention than ever before being given to primary and community health care, yet their future seems more uncertain than ever. Some community health services are now functioning as independent NHS community trusts, while some are part of combined acute and community trusts. Even more confusingly, an increasing volume of such services are now being purchased by GP fundholders as well as district health authorities – a trend likely to intensify after April 1996, when new rules were introduced allowing small practices with 3000 registered patients to become 'community fundholders', purchasing community nursing services only.

In October 1994, the then Secretary of State for Health announced her intention to lay the foundation for a primary care-led NHS through the development of fundholding practices, and subsequently issued a consultation document intended to clarify accountability procedures for fundholders (NHSE, 1995). In brief, the document sees the district health authority as the local strategic planning authority with which the fundholder is expected to work closely. Accordingly, fundholders will be required to produce an annual practice plan, and it is the local health authority's responsibility to confirm that these plans are consistent with national priorities. However, the framework concentrates upon the internal management of fundholding and has little to say about any relationship with agencies other than the NHS. Omissions include an involvement in community care planning, in providing services in respect of community care packages, assessment of children deemed to be in need and participation in joint commissioning strategies. All of this contributes to the key theme of this monograph – that service development has become a casualty of policy turbulence.

The major new hope for bringing some semblance of order into all of this is joint commissioning, practical guidance on which was issued in 1995 (Department of Health, 1995). However, it would be unwise to expect too much of such initiatives. The guidance appears to be little more than exhortatory, and the likelihood is that those localities with a history of poor relationships will have no real incentive to change their ways (Hudson, 1995).

Conclusion

This brief review of some of the changes taking place nationally with service development implications suggests that the difficulties encountered in Yorkshire during the lifetime of the King's Fund project were not unrepresentative of the wider picture. The changes ushered in by the NHS and Community Care Act 1990 broadly represent a move away from Government allocating public funds to monolithic public bodies which have combined responsibilities for identifying needs, planning services and providing them directly, towards the development of some form of quasi-market in health and social care.

The problem for service development as a distinct activity is that many of the assumptions about how to create better services have been developed out of the experience of working with precisely those kinds of unitary, provider-dominated organisations. Where does this leave service development? It points to a time of great uncertainty and challenge for those charged with making the new structures work effectively at all levels. It poses an equal challenge to those who, as users, carers, academics, pressure groups or development agencies, seek to influence the behaviour of those managing the new systems. In these circumstances, it seems timely to review what we mean by service development, as a precursor to considering the most effective ways in which service development might be pursued in the new context.

Chapter 4

Service development as a continuum of activities

Health and social care agencies often describe their plans to increase the range and quality of what they provide as 'service development'. Where, for example, community care plans show an intention to increase the number of home care hours or add to the number of residential care beds, these will frequently be referred to as 'service developments'.

The term is also used to describe the quest for better, more appropriate kinds of services in response to identified needs, as opposed to simply providing more of the same. This implies a process of research, innovation and risk, and it may be undertaken or funded by any statutory, voluntary or private body with an interest in developing the quality of services. This is the model of service development with which this monograph is mainly concerned.

Given the slipperiness of 'service development' as a concept, it might be more useful to view it as a continuum of activities ranging from experimentation and market testing at one end, to simply finding the resources to fund a service for which the need is well established. The continuum could be seen as having four points on it:

- researching new problems and piloting solutions;
- replicating successful pilots;
- selling successful initiatives more widely;
- universalising programmes with a proven track record.

Researching and piloting

The King's Fund Carers Initiative was an example of innovative activity. It was located in a number of local authority social services departments, as well as Yorkshire RHA and a London FHSA. It was intended to focus upon carers themselves and enable them to articulate their own needs to the local statutory bodies. The objective was to help those organisations understand the carer dimension, to see how the needs of the user were connected to the needs of their primary carers, and to recognise that both sets of needs had to be addressed and met simultaneously if the optimum result was to be achieved.

The development work for this project was inevitably complex and painstaking because it raised new questions and issues that had not been addressed before. It therefore contained elements of research that encompassed user opinion, practical problem solving, testing of solutions, marketing and replicating success. It also promoted shared learning and the translation of lessons learned into routine training programmes and organisational policy formation.

Selling and universalising

The lessons learned by the King's Fund from innovative work have been widely disseminated and have also informed a later initiative, Carers Impact, which offers consultancy to health and social care agencies. As a result of this, there is more widespread recognition of, for example, the need for flexible respite care to form the core of any service to carers. Information and advice on how to approach service development work with carers has also been made available, and may have contributed to the multiplicity of carer support services now being developed around the country. (Robinson and Yee, 1992; Gunaratnam, 1993; CareLink newsletters, 1987–93; Yee and Blunden, 1995; Powell and Kocher, 1996; Unell, 1996)

At the other end of the spectrum of service development activity is the task of identifying resources and the organisational capacity to put in place services for which a need has been well established. In the case of support for carers, the rapid expansion of Crossroads Schemes is one example of universalisation. It may not always be self-evident when the point of universalisation has been reached. At one of the Yorkshire sites, the need for respite care was extremely well documented locally, but when the authorities (under new management) suggested involving carers in further exploration of their needs, there was a wave of protest. From the carers' perspective, the time for research and consultation had long since passed, and they wanted action. Indeed, there is occasionally a danger that exhaustive researching of need is being used as a delaying tactic by hard-pressed or intransigent authorities.

Approaches to service development

A key theme of this report is that the environment within which services are now operating is in a state of flux, and that approaches to service development may have to be reconsidered in order to take account of this. If service development is interpreted widely as an attempt to bring about better services, then a broad range of methods for promoting this will need to be identified. This section identifies ten possible approaches.

1. The development worker

A favoured and traditional method of development work has been to employ a worker or group of workers within the organisation to be changed, and give them the brief of securing desired change. This method can be used both when the initiative for change is 'in house' or when it is being promoted by external interests, such as a governmental agency or a charitable body working on behalf of users. Indeed, this was the method used in the King's Fund Carer Initiatives across the country, and in Yorkshire it was also adopted by two of the district health authorities to further their own development plans..

However, the development worker is seldom likely to be part of the senior management forum of the organisation, and therefore has to find ways of locking into the organisation's management processes. This is usually attempted through a line manager or the establishment of a project steering group. The task of the development worker is then to build support for the goals of the project, research opportunities to develop and test ideas, evaluate the results and secure changes in policy and practice which enable the new thinking to become integral to the future functioning of the organisation.

This all adds up to a task of monumental proportion. The development worker needs the skills, expertise and experience to work the length and breadth of the organisation, as well as possibly

working across organisational boundaries, yet is likely to be operating at a relatively low position in the organisational hierarchy. New ideas and ways of working may have to be developed in the teeth of scepticism and even resentment on the part of existing staff who have no real commitment to the objectives being pursued by the worker. Without consistent top level support, this will often seem to be a hopeless task. Such support may have been effectively forthcoming under the old welfare command structures, but it is much more difficult to secure in an environment characterised by competition, organisational fragmentation and general turbulence. In Yorkshire, the experiences were not always as negative as this, but the myriad of changes did take their toll in confusion, anger and alienation. This does suggest the need to think about other approaches to developing services.

2. Task force/consultancy

In recent years, more use has been made of external consultancy to bring about change in an organisation. Typically it has been commissioned by an organisation which is either able to define the problem to be solved or knows what it wants to change and is simply seeking help to make change happen. The organisation is in a client role, and is often paying substantial sums, therefore co-operation with the consultants is likely to be insisted upon by top management. A task force is a type of consultancy established to concentrate upon development in a particular area of activity, with the assumption that expertise can be developed and transferred quickly to where it is needed. It may be set up by a private firm of management consultants who know that a number of prospective customers share common problems or by development agencies such as the King's Fund, wishing to promote certain types of change.

A task force may be used to introduce an element of external pressure upon an organisation to bring about change. It may be 'offered' along with a degree of coercion and provided free by a government agency looking to bring about change and development quickly in line with government objectives. A recent example was the Community Care Support Force which was established to support local authorities deemed to be struggling to introduce government directives on time, though in some cases a visit from the Force carried a certain amount of stigma. A Task Force may be able to exercise a degree of influence unavailable to the single development worker, but unless it is able to make an impact fairly quickly, it could lose credibility.

3. Financial inducements

Financial inducement can be a mechanism for bringing about service development or change, and although usually offered by governmental agencies, it is also a technique used by grant-awarding trusts. In all cases, the agency with the funds will have a policy objective which it seeks to fulfil by offering grants or contracts to organisations who will research, pilot or develop services in line with the funder's objectives. Progress will normally be monitored by the funder, and payment may be curtailed if the funding agreement is not being honoured. An example of this approach was the £6 million DoH project to encourage local authorities to research and develop alternatives to residential care, whereby local authorities were invited to submit proposals on how the money would be used and successful applicants given grants to try out their ideas over a three-year period. Similarly in Yorkshire, the King's Fund project was linked to an initiative by the Allied Dunbar Charitable Trust which offered up to £1 million to four voluntary organisations to develop work with or on behalf of carers.

This kind of inducement can produce quick results and lead to the emergence of exciting new ideas for development. However, it is not without its dangers. The lure of additional funding can distract organisations from ongoing work which still needs to be pursued, and it may also encourage them to tailor established work to the requirements of the innovation funder, with a consequent loss of direction. Typically, in this approach, all that is being offered is cash. It is left to the project proposer to work out how the development work will proceed, yet expertise in development may not be part of the proposer's range of skills. In these circumstances, a successful bid does not necessarily guarantee a successful outcome for the funder.

4. Contract compliance

Contracts are becoming a principal means of transferring money from one organisation to another and, depending upon how they are let, can offer considerable scope for encouraging development required by the funder. This can be approached through the contract negotiations between purchaser and provider, which should also have an involvement of users and carers. It could be approached through letting a contract with a previously determined specification into which users and carers have made their input. Or it may be approached through letting a contract for innovation similar to a contract for research in which the kind of development work which will take place is specifically documented and subject to close monitoring.

Contract conditions can also lead to developments in service provision, and this could be quite a cost-effective way of achieving change rapidly, especially when commissioners and users work together. The more health and social care is provided by trusts and independent providers, the more scope there is for contracts to be used as the mechanism for defining service specifications and ensuring that enhanced service quality is being delivered. In the past it has been necessary to channel change through in-house providers, which often involved painstaking negotiations, disputes over working practices, pay and conditions, and conflicts of professional opinion. However, many social services departments are reluctant to extend their contracting process to their in-house providers, therefore any long-standing intransigence is likely to remain.

Moreover, the cost of a poor contract can be high. If the contract specifications and conditions are less than adequate, then the funder and ultimately the user will be locked into an arrangement which may be inflexible and unsuited to their needs. And even a good contract does not result in good services if the provider does not keep to it and the commissioner does not see that it is monitored.

5. Outcome funding

The idea of concentrating upon outcomes, rather than upon inputs, process and output, is steadily gaining ground (Qureshi, Nocon and Thompson, 1994). It fosters the notion that the funder is an investor, and that both investor and project implementer should produce a project plan which tells the funder what is being bought in result terms and the probability that the results will be achieved. Specific content of the plan may include information about the changes sought and for how many people; who will be the key people relied upon to achieve targets; what milestones will indicate that the project is on course; what money is needed; and how return on investment can be defined. Outcome funding might therefore be particularly relevant as a discipline for clarifying more precisely what a particular project is setting out to change and for monitoring progress.

The difficulty with this approach is defining and measuring desired outcomes. In the case of health care, the notion of 'health gain' is seen by Ovretveit (1994) as a useful way of unifying health staff around the same goal and focusing the activities of commissioners, but Hunter (1993) sees the concept as lacking an accepted definition or any precision. Essentially, health gain is about determining whether, in meeting need, a given intervention has a demonstrable impact on health status: if it has, it represents a measurable improvement in quality of life and is an example of health gain. In principle, it should be possible to establish a similar notion of 'social care gain', but in practice such an idea is barely embryonic and needs to confront the epistemological problem that establishing the determinants of health and social care gain is not straightforward. Critical questions also arise over how a particular impact is to be measured, with the risk of measurable factors being accorded a much greater weight than those which are difficult to measure.

6. Government edict

Statutory direction is a powerful mechanism for determining what is delivered to users, and it is a tool which the Government has not shrunk from using in the community care reforms. The White Paper was followed by a plethora of Policy and Practice Guidance on a wide range of fundamental aspects of the changes, and this was then reinforced by the conditions attached to the transfer of the Special Transitional Grant. It is likely that this approach will continue for the foreseeable future, as the supply of public finance remains restricted and pressure relating to its use intensifies. Government has numerous options for directing service development, but the linking of funding to the attainment of targets is perhaps the most powerful.

The use of publicised targets and charters, performance indicators and the production of various public sector league tables can also influence the way statutory authorities take care of service delivery. Within such an approach, those interested in particular types of service change will need to ensure their causes are on the Government's agenda. Arguably, the cause of carers has been advanced more by support for carers becoming one of the six key objectives of the White Paper than by any other mechanism, though such an explanation would need to understand *why* the Government was willing to include such an objective. However, while those with influence over Government will relish the power to use those contacts to shape the agenda of local health and social care agencies, those without such influence will be understandably sceptical and may see the increased centralisation as undermining the position of those with the real knowledge of local needs and priorities.

7. Jointness, collaboration and partnership

If the new world of health and social care is seen as being potentially quite fragmented, with a proliferation of purchasers and providers who will often be in competition with one another, then there is a real threat to service development. New ways must be found to enable commissioners in health, social care and other agencies to consider their joint strategies for commissioning services, avoiding waste and duplication, and producing a cost-effective, seamless service. Ways must also be found to relate to providers, seeing them as partners in a process of achieving the optimum level and quality of services available. And if they are to be meaningful, such partnerships must include representation of user interests.

These messages seem to have been heard, with the recent encouragement given to the joint commissioning of health care and social care (Department of Health, 1995), but it would be unwise to expect such collaborative ventures to achieve early success. Much of the early effort

has been little more than a continuation of old and unsuccessful modes of joint working (but with a new name), and localities are all too often characterised by a history of conflict and mutual suspicion (Hudson, 1995). Although practical guidance on joint commissioning has been issued by the DoH, it has not been accompanied by any of the possible government edicts considered in the previous section.

8. User power

The most radical approach to service development and change would be to put the cash directly into the hands of users and carers, and let them decide how to spend it. This is the basis of the 'brokerage' model of care management developed in Canada (Salisbury, 1987) and emulated in Britain with the short-lived Independent Living Fund (ILF). In her evaluation of the ILF, Kestenbaum (1992) challenged the assumption that disabled people are incapable of exercising effective choice and control over their own service development arrangements. She found that 75 per cent of ILF users had no significant difficulty in arranging their care, and that they valued highly the power of choice and control which arose from the control of their own budgets.

Currently, it is illegal for local authorities to give money to enable users to buy their own services directly, but in some places voucher schemes are being used to enable people to determine directly with the provider when particular services will be delivered. In Bradford, for example, carers are able to use vouchers provided by the social services department to obtain respite care in the city's participating residential care homes (Chennels, 1995). More widely, the DSS subsidy to independent care homes and nursing homes from 1980 through to 1993 in effect acted as a voucher scheme for low-income users wishing to live in institutional settings. The legal position is about to change with the passing of the Community Care (Direct Payments) Bill, which will enable direct payments to be made legally, although doubts remain over the scope of this measure.

If putting purchasing power into the hands of individual users is primarily a matter for political settlement, then assisting users to assert their preferences and influence decisions is more of an issue of local organisation. The user movement in Britain is still in its infancy, and many service users are known to be reluctant to complain about poor standards of service. Although this is being changed slowly, users are likely to continue to need considerable assistance and facilitation. The use of community development techniques could be an important mechanism for promoting change in the future and could provide an important opportunity for trusts which fund innovation.

Users need to influence not only the decisions which statutory bodies make about the services which will be available, but also the process by which service specifications are developed, the determination of who gets the contracts and the process of managing and monitoring the contracts once they have been awarded. This implies the transfer of a considerable body of technical expertise to users – an expertise which is only just beginning to emerge among professionals. If this can happen quickly, it provides an important opportunity for meaningful partnerships to develop between users, commissioners and providers, as together they work out how to manage their new environment.

9. The manager as development worker

A further method for service development which should be considered is using part of the time of senior managers for the purpose. In Yorkshire, for example, one of the more successful project sites was one where a senior manager took personal responsibility for providing leadership and ongoing co-ordination. This meant that strong links into senior management were integral, and ownership of initiatives became easier to establish. A major problem in service development was thereby overcome, although as a manager with many other responsibilities, the work of further developing services had to compete with other tasks for attention. However, it may be that in a period of rapid organisational change, managers will have to find time to inform themselves about the services which users expect them to deliver through some direct contact with those users, and it will then behove them to take a personal interest in developing the means to provide those services. It may be that the process of change cannot take place in the relatively leisurely, consensus-driven fashion of the past.

10. The 'beaver' effect

Finally, in any discussion of service development, we should not forget the contribution that can be made by committed professionals who find a better way of doing something, overcoming the barriers which inhibit the achievement of positive outcomes for users. This often takes time, persistence and patience, and may result in unpopularity. The better companies in the world of industry and commerce encourage active participation of staff in the development of better services and reward those with initiative and inventiveness, but this is not a cultural habit which has yet taken root in the public sector. The encouragement of a 'bottom-up' approach to service development is especially important in community care because front-line workers inescapably have to use discretion and professional judgement in their everyday work. In such circumstances, the price of not seeking their views and listening to them is that they will effectively *make* policy through a myriad of daily encounters, but this informal policy-making may be at variance with formal strategic objectives.

Chapter 5

Where do we go from here? The prospects for community care service development in the future

The Yorkshire experience raised some interesting questions about what we are trying to do in a 'service development project' and how best we might try to achieve our aims. The overall objectives set by the King's Fund and Yorkshire RHA were quite broad.

The localities invited to participate did so on the basis of proposals for developing services at a local level which they themselves had put forward. The totality of intentions was wide, with no real clarity on why a proposal had been put forward, whose priority it was or how much time and money was to be devoted to pursuing it.

Some localities chose to research new ways of looking at needs, while others simply had the task of introducing a needed and known service. The projects in turn organised themselves in different ways to achieve their individual goals: two employed workers, others relied upon a task force, or simply left the group to fight for management attention. This sort of approach to service development may seem vague, but it is not unusual, for it has often been a traditional axiom that those engaged in development should be allowed maximum scope to be innovative and opportunistic.

It is no longer clear that this sort of approach is viable in a radically different welfare culture which is more attentive to securing value for money. An initial step in considering a fresh approach is to explore further the notion of a continuum of service development in order to tease out identifiable strands which may then be related to the tenfold menu of different approaches discussed above. Four such strands can be readily distinguished:

- a problem without a known solution;
- a problem which requires further testing;
- good practice has been proven and needs wider encouragement;
- best practice is known and must be universalised.

A problem without a known solution

If the problem is one of insufficient knowledge, then the research approach will be indicated with a view to clarifying the problem, identifying the options to be explored as possible solutions and testing them out. This may be a suitable set of tasks for a lone development person with suitable research skills, or alternatively it may be possible to consider a consultancy approach with the work broken down into research, option development, trial and evaluation.

A problem which requires further testing

The task at this stage is to further test a development which has already worked elsewhere. This may involve the transfer of skills through consultancy, but it may need to be accompanied by some kind of inducement in order to find the test beds. This may be provided by a government agency or a charitable organisation either through the provision of funding or by implying that such a development would confer status as an innovator upon the development site. Sometimes pressure from users may act as an impetus to development work at this stage, especially where there has been an advancement in treatment and people want the benefit of it. Conductive therapy, for example, was introduced into the UK largely as a result of pressure from parents who had heard of the success of the treatment at the Peto Institute in Hungary.

Good practice has been proven and needs wider encouragement

The benefits of a particular service may be well documented, but this will not necessarily lead to widespread adoption. The reasons for this are many: lack of information, unwillingness, bureaucratic preference for another kind of service, inflexibility, political ideology, lack of resources, and so forth. An initiative to develop a proven service might come from various quarters – the Government, commissioning agencies, users or an interested service development body – and the strategy for change will vary accordingly. Change could come from the voting of new resources, the reprioritisation of services, the retraining of existing staff and other means.

Best practice is known and must be universalised

When a particular service or group of services are well understood to be the most appropriate response to certain kinds of needs, concerted Government action may be required if it seems imperative that such provision is made universally available. Legislation may be the most effective way forward, and pressure put on Government for that legislation may be the most effective tactic for users. But the legislation may be only a beginning if additional expertise and skill are needed to put the developments into place – a task force or consultants may again have a role to play here.

Although this report is only dealing with ideas at a very broad level, it is possible to see that had such an analysis been applied in Yorkshire, then a different kind of service development project might have been designed. For example, the RHA might have used the King's Fund expertise from previous work actually to specify some of the services which needed to be in place to meet carers' needs and invited localities to bid to develop services from a menu offered to them. Or again, encouragement could have been given to networking with those already into similar developments. However, the design of the Yorkshire project followed much conventional wisdom which seemed valid at the time the project was planned.

This traditional approach has never been without its difficulties, but there was always a sporting chance that a lone development worker could persuade a monopolistic command hierarchy that there were better ways of doing things. Even this could only be accomplished in the right circumstances, most notably a measure of organisational stability sufficient to allow confidences to be built up, alliances formed, stakeholders convinced, resources identified, solutions designed, tested and then integrated into the structure.

By reflecting upon the Yorkshire experience as a possible microcosm of the wider picture, and by exploring some of the emerging evidence of the impact of new approaches to welfare, it seems clear that these conditions of stability are unlikely to be found in the future. In this case, the traditional model of development work is no longer appropriate, and it behoves all of those concerned with service development to explore new ways of working. At a very broad level indeed, it has been suggested that three key questions will increasingly need to be addressed, each of which will have a range of possible answers:

1. Who is seeking to initiate change?

- government
- local authorities
- commissioners
- providers
- special interest groups
- users
- carers
- development agencies
- professionals within a provider agency.

2. What kind of output or outcome is being sought?

- provide an answer to a newly identified problem
- develop a prototype solution
- replicate a successful model
- sell a model for better service
- ensure the delivery of a proven service
- increase flexibility in service provision.

3. What options are available to bring about change?

- employ a development worker
- employ a consultant
- use the contracting system
- set up a task force
- empower service users
- develop outcome-related approaches
- change the law
- use existing statutory powers
- provide financial inducements
- use existing managers
- train and develop staff
- develop collaborative partnerships.

In principle, it is possible to match up an initiator of change, a desired outcome and the most appropriate vehicles for securing such change. For example, in the case of an innovation in offering home care, the following possibilities may arise:

Government could:

- encourage, through dissemination at seminars, conferences, good practice manuals or inspection and monitoring exercises
- induce, through financial penalties or rewards
- insist, through legislation or the use of statutory powers.

Commissioners could:

- demand, through changes in their contracts with providers
- request that providers make progress in the interests of partnership development
- suggest that providers look at the innovation in the context of quality review.

Providers could:

- train managers to be developers
- offer support through a task force or consultancy
- offer financial inducements or raise the threat of loss of contracts
- adopt a strategy of constant quality improvement.

Users and carers could:

- lobby Government for legislative change
- try to influence commissioners through consultation procedures
- seek consultation with providers directly
- use any cash/vouchers only with providers offering the innovation.

This matching of change initiators, desired outcomes and development methods should not be seen, of course, as a matter of pulling the right levers for the right results. A mechanistic approach to service development is neither possible, nor desirable, nor credible. In practice, the world of policy and service development is complex and messy.

However, in the community care environment, service development activity will need to be focused on specific service changes, targeted on particular agencies and professional groups, planned with effective monitoring and evaluation built in and driven by user and carer interests. Furthermore, in times of continued organisational turbulence, service development initiatives are more likely to succeed if grounded in alliances between different change initiators who have common interests in working together across the fragmented system of community care. These alliances can, in turn, make use of a judicious mix of developmental approaches which when applied in combination act as real levers for change.

Any new service development agenda in community care will nevertheless depend upon the existence of a local service development culture. This development culture is evident when professionals and agencies share as a common *raison d'être* the pursuit of flexible and effective ways of meeting identified needs. Where such a culture is strong, the possibilities for building better services will be greater than where it is weak.

However, if localities are to be expected to build up a service development culture, then they will need both support and incentives from the centre. Service development initiatives must

become a key feature of central government monitoring activities, and must be accompanied by an understanding that co-operation is perhaps more important than markets and competition. Equally, there can be no evading the fact that the promotion of choice and independence is inextricably bound up with funding adequacy, both in terms of the total amount available and the rules attached to its disbursement. In short, service development is something which needs to be *worked* at; it has no qualities of spontaneous growth and self-perpetuation.

Failure to recognise and act upon this will doom service development to the fate of being everyone's distant relative but nobody's baby – the very description used by Sir Roy Griffiths (1988) to explain the failure of three prior decades of community care policy and practice.

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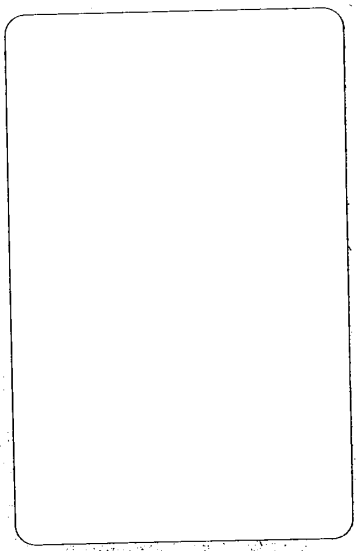

The early 1990s proved disappointing for those working to improve community care services. The organisational turbulence caused by the NHS and Community Care reforms inhibited efforts to develop better services for users and carers and showed up the inadequacy of traditional development approaches.

This report draws on the experience of a King's Fund service development initiative to illustrate the degree to which such work is hampered by periods of great change. It places that experience in a national policy context, providing insight into service difficulties arising at local level.

The conclusions offer constructive suggestions for service development approaches which are likely to achieve success in a future characterised by continuing turbulence in community care.

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