

**Defining the Boundaries: The Implementation
of Health and Social Care Policies for Adults
with Learning Disabilities**

By

Rachel Ebba Fyson, BSc.

Thesis submitted to The University of Nottingham for the degree of
Doctor of Philosophy

May 2002

Acknowledgements

Firstly I would like to thank my supervisor, Dr P. J. Standen, for her ongoing support throughout the research process and the writing of this thesis. Without her I *might* not have started, but *certainly* wouldn't have finished.

I would also like to thank Ellen Gallimore and Sue Hooper for the practical help they provided along the way.

Thirdly, my thanks go to all those busy professionals, who must of necessity remain nameless, who took time out to speak to me about their experiences of learning disability services, and by doing so made this research possible.

Finally, I would like to thank both John and Richard, who provided constant distractions along the way and generally kept me (mostly) sane.

Abstract

This thesis examines why community care policies for adults with learning disabilities have proved so hard to implement in a sustained, equitable manner, and explores the apparent chasm between official policy and actual practice in the light of current theories of social policy implementation. It focuses specifically on the relationship between health and social services, and investigates the factors which affect the ability of these agencies to co-operate effectively in the provision of services to this client group.

The study compares services in two areas of England. In each study area a series of semi-structured interviews were conducted with staff at all levels within statutory learning disability services, from senior health and social service managers to frontline practitioners. Interviews were taped and transcribed in full prior to coding. Analysis was informed by both grounded theory and discourse analytic methodologies, but is best summarised as a thematic content analysis.

Findings suggest that three major factors affect inter-agency relations and impact upon policy implementation: the complexity of service structures; professional and cultural differences between health and social service staff; and the wide variation in the local interpretation of national policy. The implications of these findings for the future of learning disability services are discussed. In particular, the need for policy makers and implementers to pay greater attention to the creation of organisational structures which encourage, rather than hinder, co-operation across traditional agency boundaries is emphasised.

1. INTRODUCTION	4
A BRIEF HISTORY OF LEARNING DISABILITY SERVICES	7
CHANGING IDEOLOGY AND STAGNANT POLICY	14
CURRENT LEGISLATIVE FRAMEWORKS	20
2. LITERATURE REVIEW	24
3. THEORIES OF IMPLEMENTATION	39
POLICY AND IMPLEMENTATION	39
WEBER'S BUREAUCRACY	42
TOP-DOWN THEORIES OF IMPLEMENTATION	44
BOTTOM-UP THEORIES OF IMPLEMENTATION	48
4. METHODOLOGY	60
RESEARCH AIMS	60
CHOICE OF RESEARCH METHODOLOGY	61
DATA COLLECTION	64
DATA ANALYSIS	67
5.1 ANALYSIS OF DATA	72
DEMOGRAPHIC AND HISTORICAL FACTORS	72
5.2.I ORGANISATIONAL STRUCTURE OF SERVICES: AREA 'A'	76
HEALTH SERVICES	76
SOCIAL SERVICES	81
COMMUNITY LEARNING DISABILITY TEAMS	88
LEAD AGENCY STATUS	93
POOLED BUDGETS AND JOINT MANAGEMENT	98
LINES OF COMMUNICATION	100
5.2.II ORGANISATIONAL STRUCTURE OF SERVICES: AREA 'B'	102
HEALTH SERVICES	102
SOCIAL SERVICES	106
COMMUNITY LEARNING DISABILITY TEAMS	108
LEAD AGENCY STATUS	118
POOLED BUDGETS AND JOINT MANAGEMENT	121
LINES OF COMMUNICATION	125

5.2.III COMPARISON OF ORGANISATIONAL STRUCTURES	128
SERVICE BOUNDARIES	128
ORGANISATIONAL STRUCTURES	129
COMMUNITY LEARNING DISABILITY TEAMS	132
SIMPLICITY/COMPLEXITY OF STRUCTURES	134
5.3.I HUMAN FACTORS – AREA ‘A’	136
INDIVIDUALS WITHIN SERVICES	136
PROFESSIONAL GROUPINGS	142
ORGANISATIONAL CULTURES	145
5.3.II HUMAN FACTORS – AREA ‘B’	153
INDIVIDUALS WITHIN SERVICES	153
PROFESSIONAL GROUPINGS	157
ORGANISATIONAL CULTURES	159
5.3.III COMPARISON OF HUMAN FACTORS	166
INDIVIDUALS WITHIN SERVICES	166
PROFESSIONAL GROUPINGS	168
ORGANISATIONAL CULTURES	169
5.4.I POLICY IMPLEMENTATION – AREA ‘A’	171
CENTRAL GOVERNMENT LEGISLATION AND GUIDANCE	171
CURRENT GOVERNMENT PROPOSALS	177
COLLABORATION AND CO-OPERATION IN PRACTICE	179
BOUNDARY ISSUES	183
ASSESSMENT SYSTEMS AND NEEDS-LED PROVISION	190
FINANCIAL CONSIDERATIONS	199
PRIVATE AND VOLUNTARY SECTORS	205
5.4.II POLICY IMPLEMENTATION – AREA ‘B’	209
CENTRAL GOVERNMENT LEGISLATION AND GUIDANCE	209
CURRENT GOVERNMENT PROPOSALS	213
COLLABORATION AND CO-OPERATION IN PRACTICE	218
BOUNDARY ISSUES	225
ASSESSMENT SYSTEMS AND NEEDS-LED PROVISION	232
FINANCIAL CONSIDERATIONS	237
PRIVATE AND VOLUNTARY SECTORS	240

5.4.III COMPARISON OF POLICY IMPLEMENTATION	243
CENTRAL GOVERNMENT LEGISLATION AND GUIDANCE	243
COLLABORATION AND CO-OPERATION IN PRACTICE	245
BOUNDARY ISSUES	246
ASSESSMENT SYSTEMS AND NEEDS-LED PROVISION	247
FINANCIAL CONSIDERATIONS	249
PRIVATE AND VOLUNTARY SECTORS	250
6. DISCUSSION	251
EMERGENT THEMES: I) ORGANISATIONAL STRUCTURE	251
EMERGENT THEMES: II) HUMAN FACTORS	263
EMERGENT THEMES: II) POLICY IMPLEMENTATION	265
METHODOLOGICAL ISSUES	268
CONCLUSION	270
7. EPILOGUE: VALUING PEOPLE	272
8. REFERENCES	275
9. APPENDIX I	301
INTERVIEW SCHEDULES	301
APPENDIX II	308
ORGANISATIONAL FLOW CHARTS	308

Chapter 1

Introduction

The aim of this chapter is to give a historical overview of the development of services for people with learning disabilities. Within this, the intention is twofold: firstly, to demonstrate how policy is created from the combined influences of previous policies (or lack thereof), public and professional opinion, academic and ideological debate, and political willpower. Secondly, to demonstrate how practice is dependent upon the attempted implementation of such policies in the face of knock-on effects of previous policies (whether directly related or not), prevailing socio-economic conditions, and the structure and availability of requisite resources.

No policy exists in a vacuum, nor does it arrive fully-fledged from out of the ether. Like many, if not all, areas of government-influenced social provision, policies concerning people with learning disabilities have developed over time in a piecemeal fashion. The direction which such policies have taken has been dominated variously by moral panic, political outrage and fiscal prudence. Over time, ideologies of care have risen and fallen in popularity, public interest has been drawn to the area only intermittently, and implementation has often lagged some considerable distance behind formal policy-making.

The most recent attempt by central government to radically alter statutory provision of services for adults with learning disabilities was the implementation in April 1993 of the community care element of the 1990 National Health Service and Community Care Act. This legislation, like any other, needs to be understood first in terms of the problems it was trying to solve. Many commentators (for example, Lewis & Glennerster, 1996; Means & Smith, 1994) have suggested that the primary motivating force behind the

Act was a desire to reduce public expenditure. That being as it may, the Act was an explicit attempt to change the nature of health and social care provision for all 'priority groups' (i.e. the frail elderly, people with physical impairments and people with mental illnesses, as well as people with learning disabilities) and to ensure that community-based services became the norm rather than the exception. In addition, the Act was also the first legislative attempt to make a distinction between health care, which was to remain the responsibility of the NHS, and social care, which was to be financed through local authorities.

Viewed positively, the Community Care Act can be regarded as a genuine attempt to realise a policy goal which had eluded successive governments for half a century. Viewed less favourably, the Community Care Act can be seen as a cynical attempt to dress up a reduction in the availability of social security benefits in media-friendly terminology such as 'choice', 'empowerment' and 'community'.

Whatever one's personal opinion in this matter, it remains necessary to turn to history to discover the origins of the Act and its place in the development of services for people with learning disabilities. Policy objectives, whether explicit or covert, cannot be fully understood other than in the context of both earlier policy initiatives from which they have developed and contemporaneous policies with which they must co-exist. It is necessary, then, to first appreciate how learning disability services have evolved through time into the tangled structure which exists today, before moving on to examine how the health care/social care divide has impacted upon current provision for this client group.

A brief history of learning disability services

Much time and effort on the part of service providers has been devoted in recent years to the problem of re-provision of services 'in the community' for adults with learning disabilities, in order to enable the closure of old, long-stay mental handicap hospitals (Korman & Glennerster, 1990; McLean, 1988). A few lonely voices (Raynes, 1991; 'Rescare' pressure group, 1995) have queried this strategy, but the vast majority of people with learning disabilities, their families, carers and friends, care professionals, and other interested parties, have joined together in condemning such institutions and to hasten their demise. Indeed, the Community Care Act is notable amongst recent social legislation for having received such wholehearted political and professional support. So, if long-stay hospitals were universally disliked, how did they come to exist in the first place and why have they proved so problematic to dismantle?

Historical evidence shows awareness of and interest in people with learning disabilities being recorded as early as the sixteenth century, through the writings of the Swiss physician Paracelsus (Digby, 1996; Ryan, 1987). His ideas of idiots as pure and uncorrupted developed from earlier folklore notions of 'changelings' (the disabled offspring of able-bodied parents) being the work of elves or demons, which persist to this day in fairy tales. At this point in time it appears that learning disability was not associated with blame, either on the part of the individual or their family. However, with the spread of Lutheran Christianity, debate arose concerning the extent to which such individuals could be regarded as human (Goodey, 1996). It also became common for parents, especially mothers, to be vilified for producing such offspring who were likened to animals and not accorded full human status.

These essentially moral arguments continued to dominate debate until the Enlightenment which, with its emphasis on rational scientific thought, created

an environment that was more conducive to methodological enquiry. The earliest interventions to improve the plight of people with learning disabilities, on more than just an individual basis, centred on small-scale educational projects (e.g. Seguin in France or the Misses White in Bath -see Jones, 1960 or Getliffe, 1996). These groundbreaking initiatives sought to prove the educability of 'idiots' and train them to achieve social and economic independence. From such philanthropic urges gradually arose the notion of secluded asylums, where those unable to cope with the rigours of the outside world could seek shelter and support (Ryan, 1987).

The onset of the industrial revolution gave rise to rapid social change and an increasing degree of government intervention into the lives of ordinary people (Fraser, 1984; Thane, 1982). The demographic shift away from agrarian lifestyles and towards urbanisation, and the industrial emphasis on speed of production, put increasing pressure on traditional networks of family and community support. These pressures could be ameliorated by placing less productive members of the community into workhouses, which constituted the earliest form of public institutional care. Such a system both relieved the pressure on poor families and, in the case of 'idiots', offered the promise of therapeutic intervention (Gladstone, 1996).

Although government action in various areas of policy, most notably the Poor Law of 1834, had already impacted upon the lives of people with learning disabilities it was not until 1845 that the first legislation was introduced which was directly concerned with this group of people. Following a lengthy Royal Commission of enquiry the 1845 Lunatics Act introduced measures that aimed to prevent miscarriages of justice, with regard to both public and private asylums. Notably it was the legal issues concerning personal freedom and rights of inheritance, rather than medical or social issues concerning treatment and care which had triggered first public debate and then government action (Jones, 1960). At this time learning disability and mental illness had yet to be

recognised as separate conditions, a confusion which remains in the public mind to this day.

The introduction of education for all under the 1870 Education Act led to increasing official awareness of an uneducable underclass that had not previously been visible. The number of people officially recognised as ‘idiots’ rose sharply. Increasing numbers of such individuals were admitted, under Poor Law legislation, to local workhouses (Digby, 1996) where their unpaid labour helped sustain the institutional care of those unable to work at all due to old age, disability or ‘lunacy’. Others entered the burgeoning network of penal institutions, where they almost certainly contributed to the high rates of criminal recidivism and so to the general moral panic over how society should deal with the deprived and the depraved. Meanwhile, amongst the upper classes, privately owned ‘madhouses’ flourished, giving rise to intense legal arguments over rights of succession and accusations of false imprisonment.

Towards the end of the nineteenth century, with the growth of government and an increasing scientific interest in eugenics, people with learning disabilities began to be perceived as not only economically unproductive, a burden on their families and society as a whole, but also as a potential threat to the health of the country's genetic stock (Ryan, 1987; Means & Smith, 1994; Felce, 1996). Public demand grew for intervention to curb the apparent increase in ‘idiocy’, which was in truth an increasing official awareness of the problem rather than any actual significant rise in prevalence.

When it came, government action took the form of the 1913 Mental Deficiency Act, although implementation was delayed by several years due to World War I (Alaszewski, 1988). This legislation introduced compulsory certification for people admitted to institutions and labelled as ‘mentally defective’ (a classification which still included the mentally ill and the morally feckless as well as the learning disabled). This legislation established for the first time a separate and unified service for people with learning disabilities, a

service, moreover, which excluded them from other welfare and mainstream educational facilities. The only 'choice' was between family care with no support or certification and likely lifelong incarceration, since de-certification and discharge after admission to an asylum was extremely rare (Jones, 1960; Parker, 1988). In little more than half a century the role of the asylum had been distorted from that of protecting the learning disabled from the outside world to protecting the outside world from the learning disabled.

Official recognition and labelling of people with learning disabilities led inevitably to increasing numbers of people being deemed to warrant such a label. Further 'scientific' advances, notably Binet's development of IQ testing as a method through which the 'mentally deficient' could be identified, provided further systematic rationale and moral justification for segregation (Alaszewski, 1988; Ryan, 1987; Clarke & Clarke, 1991). The number of people in institutions grew rapidly.

Community-based services for the learning disabled were slower to emerge. Incarceration was the perceived wisdom and the preferred option. The few non-institutional services that did emerge tended to be localised charitable endeavours, often still with a focus on education, rather than any kind of statutory provision. Nevertheless it is important to bear in mind that, even when institutional segregation of learning disabled people was at its zenith, majority of such people were still cared for by family members in the community and without the support of statutory services (Leighton, 1988).

When the National Health Service was founded in 1948, as a cornerstone of Beveridge's welfare state, services for people with learning disabilities were deemed to come under its remit (Tyne, 1982; Jay, 1996; Felce, 1996).

However, since little political or social importance was attached to the needs of people with learning disabilities, the structures created at this time were based around the requirements of other groups. Little immediately appeared to change, but the reclassification of the old asylums, which had until this time

been financed and managed by local authorities, as new 'mental handicap hospitals' has had far-reaching implications. The Community Care Act is but the latest in a long line of attempts to unravel the financial confusion that derived from this decision.

Equally significant in determining the future shape and ideological direction of services for adults with learning disabilities was the fact that this transfer of responsibility to the NHS gave government sanction to the medical profession's dominance of this field of care. Learning disability became an official sub-speciality of psychiatry, and since this time the medical profession has maintained a significant role in determining patterns of service development (Tyne, 1982).

The immediate post-war period also saw a shift in public attitudes towards people with learning disabilities. In particular the eugenics movement lost support dramatically, largely as a result of the atrocities committed in its name by the Nazi regime (Alaszewski, 1988). Nevertheless it was not until 1954 that a Royal Commission was again established to examine issues concerning the care of the learning disabled and mentally ill. The Commission's findings formed the basis of the 1959 and 1960 Mental Health Acts, and this legislation provided the framework for the first provision of services by local authorities to 'mentally disordered' people living in the community (Jones, Brown & Bradshaw, 1983). The underlying aims of these Acts were anti-institutional, with a strong emphasis on training and employment for learning disabled people, to enable them to participate as far as possible in ordinary social and economic life.

In practice, the services set up by local authorities under the auspices of this legislation tended to be used by those already living in the community. The Acts' success in achieving a significant reduction in the number of people in mental institutions was therefore negligible. The NHS remained responsible for meeting residential care needs, a duty which it fulfilled by continued use of

large, segregated institutions. Local authorities had permissive powers to provide day care and domiciliary support, but national development of such services was patchy.

This state of affairs remained largely undisturbed until the 1967 Ely Hospital scandal. The News of the World newspaper reported in graphic detail the appalling living conditions and lack of adequate care being provided in Ely Hospital, Cardiff - a large but typical institution for people with learning disabilities. More revelations followed. In 1968 The Guardian newspaper conducted investigations into the condition of residents at Harperbury Hospital and discovered similar, unacceptably poor, service provision. These discoveries, and subsequently a number of official inquiries, led to a public outcry. Change was demanded and the government responded by publishing the White Paper "Better Services for the Mentally Handicapped" (Cmnd 4683, 1971). This paper was the first explicit government recognition that hospitals and the 'medical model' might be inappropriate ways of providing care for people with learning disabilities. Targets were set for reducing the number of people living in such institutions. It also proposed, not for the last time, that the responsibility for providing services for the learning disabled should shift from the National Health Service to the social service departments of local authorities.

Until the 1988 publication of Sir Roy Griffiths' "Care in the Community: Agenda for Action", precursor to the National Health Service and Community Care Act of 1990, central government policy with regard to the learning disabled had been largely governed by the principles laid out in the 1971 White Paper. But what has happened in practice has proved to be somewhat different from the political rhetoric. What has remained constant in the years between, and since, these two landmark reports is the domination of central government policy towards the learning disabled by the stated objective of developing comprehensive community-based services and the unstated objective of reducing expenditure in this area (Baldwin, 1993).

In the aftermath of the 1971 White Paper a slow but steady diminution of numbers of learning disabled people living in long-stay hospital accommodation did begin. This trend was aided significantly by the 1970 Education (Handicapped Children) Act, which transferred responsibility for the education of such children from health authorities to local authorities and so drastically reduced the numbers of children entering the system. It was also gradually acknowledged that if facilities were to be developed in the community then there would be a need for effective collaboration between local health and social services (Jones et al, 1983). To this end 'joint planning' and later 'joint finance' mechanisms were set up by statutory authorities, at a local level, to encourage the co-operative development and provision of services for people with learning disabilities. However, despite the continuing exhortations of central government, translating the language of co-operation into effective practice continued to prove deeply problematic (Means & Smith, 1994). This moved Griffiths to comment of community care that:

"In few areas can the gap between political rhetoric and policy on the one hand, or between policy and reality in the field on the other hand have been so great" (Griffiths, 1988, p.iv).

The most significant government-backed study in the intervening years was the 1979 Jay Report of the Committee of Enquiry into Mental Handicap Nursing and Care (Cmnd 7468-1). The Jay Committee was set up in 1975, at the same time as the National Development Team (NDT) (Mittler, 1996). These two quasi-autonomous bodies examined the issues of the day in mental handicap services, primarily that of how the 1971 White Paper proposals could be turned into a practical reality. The NDT's role was to engage at a local and regional level and to encourage the development of new, community-based services. The Jay Committee concerned itself with developing guiding principles upon which such future services could be based, starting from the individual needs of people with mental handicaps and then moving on to examine how these needs could best be met (Alaszewski, 1988). This was in

contrast to the 1971 White Paper, which like other government reports had recommended an incremental pattern on change based on existing services.

When the Jay Committee published its report in 1979 it broadly restated the case for adopting the principles outlined in the 1971 White Paper. It was also strongly influenced by theories of normalisation (Wolfensberger, 1972). The report specifically recommended that community residential provision should take the form of small, socially integrated, group homes. The fact that these proposals were never fully endorsed by the Government was in part due to the fact that publication coincided with the election of Margaret Thatcher, whose Conservative party had very different priorities from those of the previous Labour administration. This attitude was due both to the cost implications of individualised community-based provision and to the fact that the report had again advocated a shift in responsibility for people with learning disabilities from the National Health Service to local authorities. This was a reflection of the idea that a social model of care was more appropriate than a medical model of care. However, the proposition that local authorities should be given additional responsibilities, hence additional finances and hence additional power, proved anathema to the Thatcher government, and no genuine attempt was made to implement the Jay Report recommendations (Means & Smith, 1994).

The eventual government reply to the Jay report came in the shape of a DHSS blue book entitled "Mental Handicap: Progress, Problems and Priorities", produced in 1980 but not published until 1987. In it the progress made towards achieving the aims of the 1971 White Paper were reviewed. It highlighted the fact that assumptions about future public expenditure levels had proved to be unrealistic. While again urging health and local authorities to co-ordinate planning for future services the recommendations fell short of backing the idea that statutory responsibility for people with learning disabilities should be placed firmly with one agency. The most significant new contribution of this report was to officially recognise and endorse the role of the family as key

service providers - a theme that has subsequently cropped up repeatedly in government guidance. The report stated, as a general principle, that:

"Each handicapped person should live with his own family as long as this does not impose an undue burden on him or them" (ibid, p.82).

It failed to clarify what might constitute an 'undue burden', but did emphasise the role of private and voluntary service providers in meeting needs.

Such ideas were in stark contrast to the principles of care that had been proposed in the Jay Report. This stated that:

"Any mentally handicapped adult who wishes to leave his or her parental home should have the opportunity to do so" (Cmnd 7468-1, p. 35).

The Jay Report was, and is, notable for being the first, and perhaps only, government-backed investigative report into services for people with learning disabilities which was not conducted either in the wake of public scandal concerning standards of care nor with ulterior aims, such as reducing expenditure. Its proposed model of services still exceeds in scope and vision the pattern of provision prevalent in many parts of the country.

So, how had a report been written which was so far ahead of its time? Or was it that the report was very much of its time, and is it central government policy that has failed to move in step with contemporary thinking on issues of learning disability?

Changing ideology and stagnant policy

When the 1959 Mental Health Act was passed, debate about how learning disability should be classified had preceded it. Both social competence and emotional maturity were accepted as criteria, along with measured level of

intelligence. Classification of learning disability according to these new guidelines gave official recognition, for the first time, that there was a social element to learning disability. Prior to this, learning disability had long been regarded as firmly rooted in organic and/or genetic causes and as such was best provided for, as with any other disease, through medical diagnosis and treatment.

The acknowledgement that learning disability was, at least in part, a social phenomenon opened the door to sociological study of the relationship between social environment and individual development. During the 1960s a number of academic studies were published which sought to demonstrate the disabling effects of institutional life. Key amongst those publications were Goffman's "Asylums" (1961), the findings from Tizard's "Brooklands" project (1960 & 1964) and Morris's "Put Away" (1969). In "Asylums" Goffman examined the social environments of what he termed 'total institutions', such as prisons and mental hospitals, and used this to explain the development by inmates of characteristic behavioural patterns. For his Brooklands project Tizard took a group of severely learning disabled children out of long-stay hospital care and placed them instead into small, family-like units in the community. By comparison with their peers, who remained in traditional institutional care, the children on the project showed a considerable improvement in their social and cognitive development. Similarly, Morris (1969) used studies of adults with learning disabilities in institutional and community settings to demonstrate how intelligence is an elastic concept, susceptible to considerable influence from social and environmental factors. She went on to argue that such evidence demanded a revision of both what should constitute learning disability and how those so labelled should be cared for.

The publication and widespread dissemination of these and other studies fed into a shift in professional attitudes, and the by now traditional dominance of the medical model of care began to be eroded. This new school of thought owed much to behavioural psychology and placed greater emphasis than

before on social needs, social competence and active social participation. Such ideas also paved the way for the acceptance of Wolfensberger's theory of normalisation, which provided much of the philosophical underpinning for the Jay Report.

Wolfensberger developed his theory of normalisation from experimental projects for people with learning disabilities in Scandinavia in the late 1960s and early 1970s. He defined normalisation as:

“The utilisation of means which are as culturally normative as possible in order to establish and/or maintain personal behaviours which are as culturally normative as possible” (Wolfensberger, 1972)

In practice, the crux of this theory was that people with learning disabilities should be fully integrated into mainstream society. This, it was held, would enable people with learning disabilities to lead more 'normal' lives, which would in turn mean that they behaved more 'normally'. It would then follow that such normal behaviour would increase the degree of acceptance shown by other sections of society to people with learning disability, on the basis that familiarity overcomes fear, and hence greater social integration would continue to have a normalising effect on behaviour. And so on and so on, in an endless cycle of positive reinforcement.

In the UK, concepts of normalisation gained widespread professional acceptance and were developed by O'Brien and Tyne (1981) into 'Five Accomplishments' (namely: community presence, choice, competence, respect and social participation), which were then used as principles to benchmark the quality of learning disability services. During the 1980s, as the re-provision of services in the community continued at a steady trickle, a gulf developed between the humanistic approach to learning disability service provision advocated by academics and professionals alike, and the resources that were being made available by the government. Normalisation was promoted by both practitioners and politicians alike, but for very different reasons (Mansell & Ericsson, 1996). Staff working in learning disability services hoped

normalisation would promote better standards of care than had been available in institutions, while the government hoped to save money.

As was noted earlier, the Thatcher government of the 1980s was not keen on increasing the powers of local authorities (Hadley & Clough, 1996). It therefore balked at the idea that local authorities should take on primary responsibility for services for people with learning disabilities. This led to a virtual impasse in policy implementation, for whereas it continued to be government policy to close long-stay institutions in favour of community-based services, as had been the official line since 1959, social service departments did not have the funds to develop new initiatives. Health services were in a similar financial dilemma since it was clear that any single-handed attempt at the transition to community-based services could not and would not be cost neutral either during transition or in the longer term (Wistow & Hardy, 1986; Davies, 1987). Both health (indirectly) and social services (directly) were also suffering the knock-on effects of the reduction in local authority budgets caused by rate-capping (McCarthy & Cameron, 1992). Policy was failing to make the transition into practice due to the simple expediency of lack of finances.

What finally brought new public monies into learning disability services, and hence renewed action on the part of service managers, was a change in government policy relating to the payment of DSS benefits to those in residential care. The intended aim of these benefit changes was nothing to do with learning disability services, but targeted at another client group altogether: the elderly (Lewis & Glennerster, 1996; Knapp, Cambridge, Thomason, Beecham, Allen & Darton, 1992). In their zeal to reduce the budgetary muscle of local authorities, the Thatcher government introduced changes in payments of the care component of supplementary benefit available to those living in residential care homes (Laing, 1993). The aim of this was to encourage consumer choice, and the development of a private market in care provision, by enabling anyone who needed or wanted residential care to opt for

private provision rather than being forced to either accept the residential provision offered by local social services or themselves pay for private placement. When these changes came into effect in 1983, there was indeed a boom in private care. As well as dramatically shifting the provision of care services for the elderly from the public to the private sector, this move was latched onto by health service managers as a way of financing the transition of services for people with learning disabilities from hospitals to community-based settings (Lewis & Glennerster, 1996; Hudson, 1994; Wright, Haycox & Leedham, 1994).

With finances suddenly, albeit unintentionally, available large-scale resettlement and hospital closure at last became a reality (Korman & Glennerster, 1990). Progress towards reprovision across the country remained patchy because it relied on a combination of both foresight from health management and enterprise from the private or voluntary sectors, since DSS benefits could only be claimed by individuals not living in statutorily provided services (Laing, 1993). Nevertheless, overall uptake of the new benefit across all client groups far exceeded government expectations. Although the creation of a flourishing market in private care was welcomed, the attendant exponential increases in expenditure were not. It was this which led the government to commission Sir Roy Griffiths to write his report (Griffiths, 1988) concerning the future of community care, which was to form the basis of community care element of the 1990 National Health Service and Community Care Act.

During this time, although policy implementation had been temporarily stalled, the ideological debate had continued to progress. Critiques of normalisation (Brown & Smith, 1992; Hattersley, 1991) were appearing which questioned whether the theory, when put into practice, pressurised people with learning disabilities into conforming to spurious notions of the 'normal', thus devaluing their individuality. Two strands of this debate in other areas were also of relevance to people with learning disabilities. Firstly, feminist perspectives on

care had become part of mainstream academic enquiry (Graham, 1993) and had increasingly led to a questioning of the unspoken assumption evident in much government policy that women could and should provide unpaid care in the home to incapacitated family members. Secondly, the voices of people with disabilities were beginning to make themselves heard through the emerging disability rights movement. Through a combination of direct action, self-help initiatives and parliamentary lobbying, disabled rights groups put forward a cogent argument to challenge the notion of dependency that had dominated government responses to disability (Morris, 1991). An alternative model of independent living was proffered, based on the principle that physical and social need are not innately connected and that if a disabled person's physical needs are met they are then able to lead autonomous, independent lives (Shakespeare, 2000).

These largely left-wing academic and social debates found echoes of approval from within the increasingly politically dominant New Right school of conservative thought. Although not fundamentally concerned with disability or carer issues this movement shared a language of individual autonomy, rights and empowerment. So it was that the Griffiths report, with its recommendations for comprehensive community-based domiciliary and residential services, accessed by needs-led assessment, and the promise of a choice of service providers gained approval in almost all quarters (Shepherd, 1990; Heginbotham, 1990).

Current legislative frameworks

Overall, the NHS and Community Care Act (1990) aimed to distinguish between health care needs, which were to be met from health service funds, and social care needs, which were to be the remit of local authority social services departments. The community care element of the Act had three main

strands, bearing in mind that the primary client group at which these reforms were aimed was the elderly. Firstly, residential care was no longer to be funded from DSS benefits; instead, such care was to be financed by local authorities (the transfer of funds was phased in over three years). Secondly, after an assessment of need, a package of care was to be tailored to individual need, with the emphasis on providing care to support independent living in a person's home and reducing the demands for residential provision. And thirdly, new recipients of care were to have their needs assessed and purchased by social services, but the care was to be provided by the private or voluntary sector.

The financial effect of these changes was to cap what had previously become an open-ended budget (Lewis & Glennerster, 1996). Whereas DSS benefits rules had required only a financial means test, under the new regime this was preceded by an assessment of need. Moreover, since local authority budgets were fixed rather than open ended, the level of assessed need at which services were triggered could be altered in order to stay within budget. Individuals had a right to be assessed, but no inherent right to services if they were not deemed to be sufficiently needy (Mandelstam, 1995).

In broad terms, the impact of this legislation on services for people with learning disabilities was to increase the extent of provision underwritten by social services. However, since the Act did not place the responsibility for financing such services firmly within the remit of either health or social services, improvements in provision have continued to be marked by only slow progress. At the heart of the problem lay the impossibility of making an objective distinction between health care needs and social care needs. This was recognised by the government, who in 1992 issued guidance to both health authorities (HSG[92]42) and local authorities (LAC[92]15) outlining the respective responsibilities which each agency had for meeting the needs of their learning disabled population. However, despite this, geographical inequalities in the availability of learning disability services continued to arise

(Hunter & Wistow, 1989; Singh, 1995) as newly formed health trusts and social services departments each interpreted health and social care according to their own principles and drew their service boundaries accordingly. Far from creating a 'seamless' service for people with learning disabilities, community care had led to a situation whereby policy implementation was riven with disagreement and public organisations were fighting to avoid financial responsibility for clients and services.

Since the 1997 election of the New Labour administration a more managerial approach to public services has been identified (Cutler & Waine, 2000). There have been no major changes in learning disability policy, but services have been greatly affected by the deluge of official documents relating to both health and social services. The most high profile proposals, some of which have now passed into statute, have concerned the health service. "The New NHS: Modern, Dependable" (Cm 3807, 1998) set out how the new government planned to alter the structure of NHS services by dismantling the internal market and creating Primary Care Groups (PCGs) to control and co-ordinate all primary health care, in close co-operation with social services. This was followed by "Our Healthier Nation" (Cm 3852, 1998), which set out health priorities and specified targets to tackle heart disease, accidents, cancer and suicide. 1998 also saw the publication of "Modernising Social Services" (Cm 4169), which emphasised not only changes in tendering for contracts, but also the need to improve partnerships with local health services: it also introduced the idea of enabling health and social services to pool their budgets.

The 1999 Health Act legislated upon many of the proposals contained in the previous year's White Papers. It has become possible for health and social services to pool budgets if they choose to do so. Many PCGs have now become autonomous Primary Care Trusts, with responsibility for planning and implementing Health Improvement Programmes in their area and a duty to act in partnership with local authorities. It would seem logical that health's services for people with learning disabilities should be located within these

new structures, but this has not happened. It remains to be seen whether this will change, and what impact this will have on learning disability services.

Within learning disability services two key pieces of guidance have focused on health provision. "Signposts for Success" (DoH, 1998a) provided guidance on commissioning and providing all types of health services for people with learning disabilities. It strongly emphasised the need for health services to act in partnership with other agencies, including local authorities, in order to maximise health outcomes. The following year saw the publication of "Once a Day" (DoH, 1999a), which aimed to increase awareness of the needs of the learning disabled population amongst mainstream primary health care teams.

A key theme of the Blair government has been to promote 'joined-up thinking' in relation to all areas of public policy. However, despite the fine words of documents like "Partnership in Action" (DoH, 1998b), reports into the state of learning disability services such as "Moving into the Mainstream" (DoH, 1998c) and "Facing the Facts" (DoH, 1999c) continue to highlight confusion over the roles and responsibilities of health and social services. The latter of these two reports, "Facing the Facts" (DoH, 1999b) contains a particularly damning summary of the state of relations between health and social services. It notes that:

"There was striking evidence of confusion and sometimes conflict, about agency responsibilities and funding, particularly for long-term care" (ibid., p.4)

And goes on to comment how:

"Confusion about the future roles and funding responsibilities of the NHS and local authorities has obstructed effective local collaboration in the re-shaping of service models in the community" (ibid., p.5).

The ideals envisaged in the Community Care Act, of harmonious co-operation between health and social services resulting in 'seamless' learning disability services would, on this evidence, still appear to be elusive.

Chapter 2

Literature review

The academic literature on both community care in general and learning disabilities in particular has burgeoned over the past two decades. The first thing to note when approaching such wide-ranging subject matter is how many different meanings the term 'community care' can have, and the huge variety of topics which can be included. The breadth of this subject matter is ably covered by Bornat, Pereira, Pilgrim and Williams (1993) whose anthology starts from first principles, questioning what community is and what constitutes care, before going on to examine issues of policy and practice. This take on community care, and others like it (e.g. Titterton, 1994), makes it clear that the subject is wider than simple government legislation and statutory service provision. In reviewing this large and varied body of writing the aim, therefore, is to give an impression of the main themes that previous authors have chosen as their focus, and to highlight those areas which are of particular relevance.

The aim of this study is to explore why community care policies for adults with learning disabilities have proved so difficult to implement in a sustained and equitable manner. With this in mind useful introductory texts, which tackle the community care issues largely from a policy perspective, include both Means and Smith (1994) and Leff (1997). Also of particular interest is the volume by Lewis and Glennerster (1996), who focus specifically on the Community Care Act's troubled implementation.

The volumes mentioned above are all concerned with the overall picture of community care, rather than focusing directly on any one client group. In practice this means that, because the elderly constitute the majority of those receiving community care services, many authors take a perspective that

highlights the needs and concerns of this client group, which may differ from the needs and concerns of adults with learning disabilities. For example, whereas the key desire for an elderly person may be to preserve their independence by continuing to live in their own home, an adult with learning disabilities might wish to leave the parental home in order to achieve a greater degree of independence.

Accordingly there has developed a body of work which focuses specifically on issues relating to learning disability, aimed at the interested lay person or practising professional, as well as those with a more academic interest in the subject area. Both Ryan and Thomas (1987) and Leighton (ed., 1988) provide useful histories of service development in the area of learning disability, with the former emphasising the social and political context of such developments and the latter providing a contemporary assessment of many aspects of service provision. Since then a number of authors have provided updated analyses of developments in learning disability services' policy and practice (Wright, Haycox & Leedham, 1994; Malin, 1995; Philpot & Ward, 1995; Mittler, 1996), while others have re-examined the wider social context of learning disability (Baldwin & Hattersley, 1991) and challenged the principles of normalisation upon which many services are now based (Alaszewski & Ong, 1990; Brown & Smith, 1992).

Most of these broad introductory texts implicitly assume that, whatever the achievements of community care, it has failed to deliver an equitable national system in which assessment of need is the sole basis upon which eligibility for statutory services is determined. However, given that this is such a widely held view, surprisingly few studies have attempted to prove this important fact. Fortunately those studies which have examined geographical inequity in the distribution of community care services are sufficiently authoritative as to leave little doubt that such inequity exists. Hunter and Wistow (1989) amply demonstrate how community care services for all client groups vary both within and between the constituent countries of the United Kingdom. They

also clearly map the organisational context for these variations in service provision both in terms of centre-local relationships within government and in terms of differences in priorities, planning and policies between the National Health Service, Social Services Departments of local authorities and the private and voluntary sectors. In contrast, Singh (1995) looks purely at community care services provided for adults with learning disabilities in the wake of the Community Care Act's implementation. He examines individual outcomes of care management and assessment practices, rather than taking a wider organisational approach, and concludes that the outcomes of this system are a lottery so far as people with learning disabilities are concerned.

However, it is not only independent researchers who have charted the inequities of community care services. The Audit Commission (1986; 1989; 1992a; 1992b; 1992c; 1994; 1996) has produced a whole series of studies, which collectively trace the development of community care practice from before the Griffiths Report (1988) through to the outcomes of the Community Care Act's implementation. The earlier titles (Audit Commission, 1986) in this series highlight the slow transfer of provision from hospital to community settings, the financial disincentives for health services to change and the increasing burden being placed on cash-strapped local authorities. The 1989 paper specifically examines prospects for community care services for adults with learning disabilities. It concludes that there exists a huge inequity between new services being provided in the community for people leaving long-stay hospital as compared to services available for those who have always lived in the community with their families. In effect, those families who sought to support their learning disabled relatives at home were penalised twice over: prior to the move towards community care they received less statutory support than was given in hospital settings, and once deinstitutionalisation got under way those already living in the community found it virtually impossible to gain places in the new group homes.

The three Audit Commission papers published in 1992 each focused on a different aspect of the changes to be implemented in April 1993. The paper concentrating on community health services (Audit Commission, 1992a) highlights the lack of clarity at the boundary of health and social care services and points to problems experienced by those people requiring complex packages of care; the paper on personal social services (Audit Commission, 1992b) refers to the lack of planning for non-hospital services for adults with learning disabilities; whilst the third paper (Audit Commission, 1992c) emphasises how a failure to define the boundaries of health and social care was creating financial tensions between organisations and hampering attempts at co-operative service provision. The two later papers (Audit Commission 1994 & 1996) follow the progress of the Community Care Act's implementation. The first Audit Commission assessment of the aftermath of the Act's implementation, in 1994, paints a fairly positive picture of service developments. The success of authorities in setting eligibility criteria and assessment procedures is praised, but the report also points to the need to develop more sophisticated systems for gathering data to use in the planning of future services. By 1996 the Audit Commission's analysis of continued progress with community care is somewhat less rosy and the report comments directly that inequities in service provision were clearly emerging.

A common theme of the above reports, as well as of many other writings, is an emphasis on the need for increased financial investment in community care services. Due to the peculiar vagaries of the method by which central government calculates how much money each local authority will receive (see Glennerster, 1992, chapter 5, for an explanation of how central-local financial constraints operate), much inequity has a financial component. There now exists a sizeable literature on the economic aspects of community care and learning disabilities: Beacock and Tait (1997) provide an excellent introduction to the main issues in an essay entitled "Economic Dimension of Learning Disability". In it they start by explaining the basic economic principles of demand, supply and cost-benefit analysis before going on to

examine how the application of free market principles to statutory services has affected both which services are funded and how they are provided. Of particular significance is the way in which Beacock and Tait make explicit the effect of market reforms on people with learning disabilities, who frequently have little financial or political clout. They point out that choice is an essential element of the market, in terms of measuring both 'optimum utility' and 'quality of life'. But emphasise that, although such measures generally give the opportunity to measure service outcomes from a client's point of view:

"Such an approach presents problems for the person who has disabilities which inhibit their capacity to communicate their needs and preferences effectively" (ibid., p.257).

Other writers have also chosen to examine the equity aspects of recent health and social care reforms. Evandrou, Falkingham, Le Grand and Winter (1992) conclude that neither primary health care services nor domiciliary care services for the elderly were distributed equitably, since factors other than need affect the allocation of such services. Whitehead (1993) assesses the equity implications of the introduction of the 1990 NHS market reforms and finds early evidence that:

"In the new contract culture deals have been struck which deliberately give preference to some patients over others, on financial rather than clinical grounds" (ibid., p.240).

Possible means of improving both equity and efficiency in community care are surveyed by Davies and Knapp (1994), but they conclude that research so far had concentrated on organisational structures and processes rather than on outcomes measures, equity or efficiency. Despite this assertion by Davies and Knapp (ibid.) there do exist at least two distinct strands of writing on the economic aspects of learning disability that are of relevance to issues of equity and efficiency in the delivery of services. The first of these looks at how costs can be measured and the second examines assessment of quality of life.

It is axiomatic that before any assessment of economic and related phenomena is possible there needs to exist a means of costing the financial inputs into a service. However, as many authors have highlighted, costing community care services is far from simple (Hoyes, Means & Le Grand, 1992; Wright & Haycox, 1991; Wright, Haycox & Leedham, 1994; Beecham, Hallam, Knapp, Baines, Fenyo & Asbury, 1997). Costs of individual care are composed of numerous independent factors (Knapp, Cambridge, Thomason, Beecham, Allen & Darton, 1992) and although residential care constitutes the largest proportion of overall costs, followed by the cost of day care, there are also many other hidden costs to health and social care services. These hidden costs include primary health services such as GPs, dentists, opticians and chiropodists, as well as more highly specialised interventions such as psychology, speech therapy, physiotherapy and occupational therapy. It is also important to note (Wright & Haycox, 1991; Wright et al, 1994) that not all costs of community care are borne by the public purse. Caring for someone at home has huge cost implications for the individual or family concerned, most obviously in terms of loss of potential earnings, but also in terms of costs to the carers' physical, mental and social wellbeing. Economic inequity is also compounded by the wide variation in charging policies for care services provided by local authorities (Baldwin & Lunt, 1996). Charging policies were shown to vary according to the financial pressure being experienced by the local authority in question rather than in relation to the ability of an individual to pay.

The second major equity-related aspect of learning disability is the issue of quality of life, and how this can be assessed. Quality of life issues are relevant since if there is no agreement as to what constitutes quality of life, and how statutory service should be configured so as to maximise quality of life for service users, then it follows that there can be no agreement as to how policy should be implemented. As has already been noted (Beacock & Tait, 1997) there are serious questions as to whether quality of life measurements have true validity if the individuals whose lives are being assessed are unable to

speak for themselves. However, this has not deterred numerous attempts at objectifying quality of life for people with learning disabilities, and to compare the differences in quality of life afforded by different types of services (Davies, 1987; Knapp, Cambridge, Thomason, Beecham, Allen & Darton, 1992; Cambridge, Hayes & Knapp 1994; Felce, 1996). Interestingly, there appears to be no overall agreement on this issue. The studies mentioned above appear to largely accept that per capita expenditure on people with learning disabilities was lower in long-stay hospitals than it is in community-based services. They disagree, however, as to what this implies in terms of quality of life outcomes. Davies (1987), Felce (1996) and Knapp, Cambridge et al (1992) all offer variations on the theme that the difference between hospital and community costs can be explained not only by possible losses in economies of scale, but also because community services offer a higher quality of life than those which were provided in the old hospitals. Notably, however, whereas Knapp, Cambridge, et al (ibid.) conclude that the extra expense incurred by the transfer of services from hospital to community-based settings had resulted in qualitatively better outcomes for clients, in their follow-up study (Cambridge, Knapp et al, 1994) it was found that there are:

“No links between costs and outcomes” (p.77).

This raises the question of how quality of life can be improved, if it is not determined simply by levels of expenditure. More recent studies (Dagnan, Ruddick & Jones, 1998; Srivastava & Cooke, 1999) comparing quality of life for people with learning disabilities before and after leaving long-stay hospitals appear to confirm earlier findings. Both of the above studies assert that positive trends in life quality have been revealed. However, all assertions that quality of life have improved need to be examined closely. The study by Srivastava and Cooke (1999) reported that:

“Positive changes are seen in engagements and management practice, negative changes in rates of challenging behaviour, depression and autism and a mixed picture in health, skills, leisure, quality of home life and staffing” (p.40).

The fact that they feel able to conclude that this demonstrates an overall improvement in quality of life perhaps reflects the authors' desire to uphold the orthodoxy that community-based services are always best. Dagnan et al (1998) come closer to recognising this when they explain that their data were gleaned from both clients and carers, and they acknowledge that further study of:

"The difference in perception of quality of life between carers and people with intellectual disability would be useful" (p. 11)

This finding thus echoes Beacock and Tait's original assertions.

Despite the lack of truly objective means of measuring quality of life, attempts at defining it remain important because the ultimate goal of all public services is to support the best possible quality of life within the limits of financial constraints. Programmes of hospital closure were embarked upon in the belief that not only would community-based services prove less costly to finance, but they would also offer a better quality of life to people with learning disabilities. The most comprehensive study of the closure of an individual long-stay learning disability hospital was that concerned with the rundown and closure of Darenth Park Hospital in Kent. Wing (1989) focused on the effects upon former patients of the resettlement process, whilst a simultaneous study (Korman & Glennerster 1990; Glennerster & Korman 1986) was undertaken of the political, policy and planning processes involved. Like Cambridge et al (1996), Wing concludes that skill levels increased most markedly in the first year following resettlement and stabilised thereafter. The reasons for this skills plateau could be numerous, but as a phenomenon it closely mirrors the plateau noted in improvements to quality of life recorded after hospital discharge by Dagnan et al (1998). It is easy to presume that residents reaching the limits of their capacity caused this effect, but an alternative explanation is offered by Mansell (2000) who notes that second-generation community-based projects:

"Are not achieving their potential when compared with the demonstration projects of the 1980s" (p.18).

Mansell states this in the context of research to compare the quality and costs of three types of residential care for people with learning disabilities: village

communities, residential campuses and dispersed community-based supported housing projects. He concludes that all three forms of provision continue to provide people with learning disabilities with an unacceptably poor quality of life in significant areas, including social integration, employment and health.

Within this he found that:

“Village communities are stronger on safety and organisation than on social integration, dispersed housing is less institutional but also less organised, residential campuses are more likely to offer health checks and other assessments than dispersed housing but on most respects are more institutional and offer care of a poorer quality” (ibid.)

If hospital closure has proved to engender the most dramatic changes in quality of life, then that is because it also constitutes the greatest shift in service provision. The transition from hospital to community settings has dominated policy and service planning for people with learning disabilities for over two decades, but whilst successive governments have continued to promote deinstitutionalisation the practical elements of turning policy into practice have been left largely to local players. In their study of Darenth Park, Glennerster and Korman (1990) conclude that both local and national authorities:

“Simply seemed to have no conception of the complex political and administrative tasks involved” (p. 103)

They painstakingly describe a process plagued by shortsightedness, delay and failures of inter-agency co-operation. These findings do not appear to be unique: both Castellani in New York (1992) and Mansell in Glasgow (1999) report similar difficulties in achieving a co-ordinated approach to a task involving such a plethora of independent organisations. Overall, there appears to be a broad consensus that the process of resettlement and hospital closure requires not only careful planning but also close co-operation between all agencies involved.

Problems associated with trying to achieve effective co-ordination and collaboration between health and social care agencies cropped up repeatedly in many contexts, not just during programmes of hospital closure. Given that co-operation between health and social care services appears to be a pre-requisite of effective and equitable implementation it is not surprising that it has attracted the attention of many writers. Many, if not most, government reports within the health and social care spectrum from Griffiths (1988) onwards have stressed the need for co-operation at all levels between health and social services. In practice, this has proved extremely hard to mandate. Several authors (Cambridge & Knapp, 1988; Wistow & Hardy, 1986; Knapp et al, 1992; Lewis & Glennerster, 1996) provide accounts of how central government has attempted to use its financial powers to force local agencies to work together, albeit with limited success. Research continues to show that joint working between health and social services remains problematic in many parts of the country (Fruin, 1998; Todd, Felce, Beyer, Shearn, Perry & Kilsby, 2000).

The difficulties apparent in adopting a co-ordinated approach to service delivery was widely appreciated by academics and many felt able to offer models of how joint working should or could be approached (Challis et al 1988; Ovretveit, 1993; Wistow, 1994; Nocon, 1994; Hudson, 1995a & 1995b; Perkins & Allen, 1997; Greig 1999). However, the models proposed comprised almost exclusively of plausible general reasons why co-operation was hard to achieve, rather than concrete 'how to' blueprints which could be of direct practical use. The exceptions to this trend were the few articles based on actual empirical research and not mere academic conjecture. Although few in number these studies were able to offer potentially useful advice. Higgins' 1994 study of an experiment with joint provision between health and social services in Leeds identified three core issues which created problems in joint working: cultural, professional and organisational factors. Meanwhile, in Manchester, Burton and Kellaway (1995) advocated 'specialization without separation'. They report the benefits to be gained from jointly managed

services and provide a comprehensive description of the steps they had taken to achieve this.

It was not only relationships between health and social services that were examined. Arblaster et al (1996 & 1998) looked at the need for three-way links between housing, health and social care agencies and conclude not only that there exists:

“A widespread lack of understanding of the roles and responsibilities of other agencies and the boundaries between them”(1996, p.1)

but also that the government is failing to set the national agenda on issues of service co-ordination. In a similar vein, both Thistlethwaite (1998) and Rummery (1998) look at the changing relations between primary health services and social care. Thistlethwaite believes that the desire to co-operate is strong from the perspective of both GPs and social service departments, but that in practice the difficulties in achieving co-operative action are overwhelming. Rummery emphasises how constant radical changes in service structure serve to direct organisational attention inwards and so hinders the development of joint commissioning.

Echoing the literature on the practice of inter-agency co-operation is that of joint planning. Here, again, there is a tendency for the authors to describe rather than analyse and to give general rather than specific advice on how matters could be improved (Wistow & Fuller, 1983; Glennerster et al 1983; Wistow & Brooks, 1988; Pettigrew et al, 1992). There were, however, some useful insights to be gained into how lack of co-ordination between Whitehall departments feeds into lack of effective co-operation between local agencies (Chant, 1986; Challis et al, 1988).

Another possible cause of inequity in the system is implementation deficit. Griffiths' comment that:

"In few areas can the gap between political rhetoric and policy on the one hand, or between policy and reality in the field on the other hand have been so great" (Community Care: Agenda for Action, 1988, p.iv)

is frequently quoted in this context. Griffiths was referring to the lack of action on community care prior to the 1990 Act: developments since that time appear not to have closed the gap. Commentaries in the wake of the initial, delayed, implementation of the Community Care Act (Henwood et al, 1991; Towell & Beardshaw, 1991; Hudson, 1994; Wistow, 1995) all point to the lack of active government support to back local initiatives, to resource shortages and to the schism of objectives between central policy makers and local practitioners. This does not appear to be simply a consequence of policy changes and service re-structuring, since Hardy et al also reached similar conclusions in 1990, prior to the Act's implementation. Early findings from the British Medical Association (1995) also concluded that GPs had seen few benefits from the reforms, with over half reporting an increase in workload but only 16% feeling that their patients' needs were being met satisfactorily after care assessment.

This review has purposely not covered the extensive literature that focuses more closely on individual needs and outcomes, other than on the issue of quality of life. Where the individual client and service structures collide, however, is in the practice of care management. Under the provisions of the Community Care Act all access to social care services was to be mediated by the care management process. It was intended that this process would consist of an individual assessment of need in order to ascertain exactly which services would be of most benefit to the client concerned: if such services as were required did not already exist then, so the theory went, they should be created. The overall intent was to make services needs-led: services should be created which fitted the needs of the clients, rather than clients having to be fitted into existing services. For more detailed descriptions of the care management process see Richardson (1995) and Elwell, Platts and Rees (1995).

Early research evidence (Hudson, 1993) showed that care management was having to fight hard to overcome:

“Entrenched service-led practice and thinking” (ibid, p. 115).

More specifically, it was found within learning disability services that a care management approach to hospital resettlement (Richardson & Higgins, 1993; Higgins & Richardson, 1994) had failed because care managers had too little influence on planning priorities and finance allocation to get new services off the ground. Other writers (McGrath & Grant, 1992; Ovretveit, 1993) locate the care management process within the broader organisational context of information gathering and service planning. These two papers both draw attention to the need for more effective co-ordination in order to achieve planning based on collations of properly recorded unmet need. Despite care management's original lofty aims of creating truly needs-led services, a recent paper by Waterson (1999) suggests that the nature of assessments undertaken under the guise of care management has already subtly turned away from being needs-led towards a role which encompasses both risk management and resource rationing.

Care management assessments are where the ‘street-level bureaucrats’ of community care are located. There is beginning to emerge a small but significant literature which engages specifically with Lipsky's concept of street-level bureaucracy and attempts to use this to explain difficulties of implementation in practice. In the USA, Maynard-Moody, Musheno and Palumbo (1990) suggested that, contrary to traditional management theories, the best way to minimise inequity arising from the autonomy of street-level workers is to increase the involvement of those workers in the policy process; whilst Meyers, Glaser and MacDonald (1998) question whether changes in formal policy were followed by changes in actual practice by frontline staff. In the UK a street-level approach has been adopted by both Hudson (1993) and Wells (1997) as a perspective from which to analyse, respectively, local social care services for the elderly and recent literature on community mental health teams. Wells concludes that:

“Managers and policy makers may have a vested interest in not scrutinizing practitioners' implementation of policy too vigorously as a way of deflecting responsibility for its consequences” (ibid, p. 333).

So what, in summary, is known about the implementation of health and social care policies for adults with learning disabilities? Services are not spread evenly across the country. Whilst local authorities are legally required to undertake individual assessments of need they are not obliged to meet all unmet need since they are free to set their own service thresholds in accordance with the available resources (Mandelstam & Schwehr, 1995). Health and social services, in theory, co-operate in the provision of ‘seamless’ services, but in practice this ideal is frequently confounded by inadequate planning systems; ideological rifts between professional groups; lack of a supportive national framework from central government; and a chronic shortage of resources. Despite the heavy emphasis within the literature on analysis of publicly funded community care services the majority of adults with learning disabilities continue to live with their families and receive little other support (Parker, 1990; Todd & Shearn, 1996; Prosser & Moss, 1996).

There is also a slow but growing awareness that service improvements cannot be implemented as intended without the co-operation of frontline staff. Importantly, the differences between staff, as well as their shared values, are beginning to be researched. Of particular relevance to this study is the work relating to community nurses and social workers. Shaw (1994) provides a comprehensive study of moves towards inter-professional training within the field of learning disability, whilst Fowler, Hannigan and Northway (2000) report a positive response to shared post-qualifying training of a group of community nurses and social workers. It would appear, however, that more than shared training opportunities will be needed in order to overcome some of the barriers to effective teamwork erected by the barriers of professional roles. Brown, Crawford and Darongkamas (2000), in a qualitative study of professional roles, boundaries and responsibilities within three

interdisciplinary mental health teams, found evidence that boundaries between professions were as ingrained as ever and that:

“Flatter, less demarcated structures are actually encouraging boundaries rather than eroding them” (p. 434).

Finally, an emerging academic interest in the culture of learning disability services has pointed to ways in which the quality of services could be improved through addressing staff issues. It has been shown that staff who viewed their employing organisation positively were less likely to suffer from emotional exhaustion (Blumenthal, Lavender & Hewson, 1998), and that there was a relationship, although not a causal one, between role clarity and burnout. Another study (Hatton, Rivers, Mason, Mason, Emerson, Kiernan, Reeves & Alborz, 1999) took this one stage further and analysed the effect on staff of any mismatch between the actual culture of their organisation and their ideal organisational culture. Amongst other findings, this study showed that whilst there was some variation of culture between separate services, staff of all types within a service tended to share a cultural outlook. If this shared service culture could be unified across all services, then there may be a hope that services could eventually achieve a more equitable outcome for people with learning disabilities.

Chapter 3

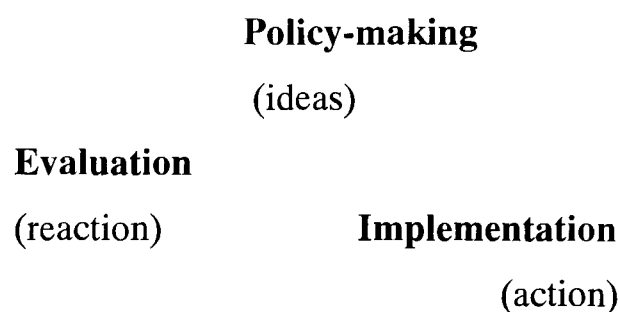
Theories of implementation

This chapter will start with an examination of the concepts of policy and implementation before moving on to provide an overview of the main strands of implementation theory. As these theories are expounded upon it is hoped to demonstrate the extent to which each of them reflects the reality of implementing health and social care policies today.

Policy and implementation

Politicians make much of their policies. Massive amounts of time and energy are devoted to ensuring that politicians' ideas are adopted as party policy or, if they are the party of Government, pass into law. Parliamentary debate may rage for weeks over the inclusion of one legislative clause at the expense of another; select committees gather evidence and produce minutely detailed reports; and special interest groups routinely employ lobbyists whose remit is to influence policy as it is being made. What this entertaining Westminster circus frequently fails to acknowledge however is that policy is not a fixed entity and may not be wholly, or even largely, determined by its written form.

‘Policy’ is at best a nebulous concept, meaning different things to different people, and ‘policy-making’ is but one phase in the continuing cycle of government. A simple diagram, as shown overleaf, can be used to represent the cycle of policy formulation and revision. Seen in this light, policy-making is revealed as just one element within an ongoing process.



Each of the terms shown above in bold represents the summation of a multiplicity of interwoven factors including party-political, economic, socio-cultural and practical considerations; the outcomes of previous policy initiatives; the inertia of existing systems and the vagaries of (media-manipulated) public opinion. Bearing all this in mind the apparently simple cycle of the policy process is revealed as an intricate interplay of diverse influences; and at this point it becomes pertinent to attempt to define the terms ‘policy’ and ‘implementation’.

The term policy is generally used to refer to the stated goals of a political party, as described in their manifesto during elections or as outlined in the Queen's speech at the beginning of each parliamentary year. This may encompass a broad spectrum of promised actions, ranging from very specific and well-defined single issues (e.g. to raise the basic rate of income tax by one pence in the pound at the next budget); through complex yet clearly demarcated legislative proposals (e.g. to pass a bill outlawing discrimination on the basis of age); to general statements of intent (e.g. to reduce social inequality). Policy, then, can be defined as a statement of intent or ‘something upon which action has been promised’.

Political ideas or statements of intent (a.k.a. policy) require action in order for their aims to be realised. These actions are termed implementation. However, it is not always easy to draw a clear distinction between policy and implementation. As Barret and Fudge (1981, p.11) put it:

".... where policy stops and implementation begins depends upon where you are standing and which way you are looking."

This is not mere semantics. A senior civil servant in Whitehall, whose role is to translate manifesto pledges into workable legislative form, might be regarded by politicians as an implementer. But the same individual could equally well be regarded by a lobbyist, or by those involved directly in the provision of public services, as the creator of policy. Some have argued (Lipsky, 1980; Barrett & Fudge, 1981; Hill, 1981; Ham & Hill, 1984) that this dual function of policy-making and implementation continues down the chain of government and managerial control right up to the point of service delivery, leading Hyder (1984, p.1) to remark that:

*"As an **activity** implementation constitutes an important, even a central, phase in the policy process. As a **concept** it has proved somewhat elusive".*

As will be demonstrated later in this chapter, different theories of implementation have chosen to regard policy and implementation as either irrevocably intertwined (ibid.) or clearly distinguishable (Pressman & Wildavsky, 1973; Hood, 1976; Dunsire, 1978; Gunn 1978). The differences between these two approaches is not merely academic but has significant ramifications in terms of how policies should be formulated in order to best predict and control the outcomes of implementation. In either case, implementation can be taken to include within its parameters the actions required by any and all individuals between the point at which a policy is declared and its eventual achievement. Or, to summarise in a different way:

"A policy is a hypothesis which must be tested, and implementation is the process of testing." (Lewis, 1984, p.205)

So, what actually happens to a policy during its implementation? And why are stated policy aims so seldom realised in the manner envisaged by its proponents? These are the questions that implementation theories attempt to

answer. And, just as in the previous chapter it was necessary to turn to history to understand how the current provision of learning disability services had come about, so this chapter must chart the attempts of successive waves of academics to understand and theorise the process of policy implementation. This section will start with a summary of Weber's thinking on bureaucracy, since this remains the form of social administration upon which the welfare state largely relies.

Weber's bureaucracy

Max Weber, one of the founding fathers of modern sociological thought, was concerned with making explicit the fundamental concepts that underpin social structures. Weber made a distinction in his writings between 'power', which he saw as the ability to force behaviours upon others, and authority', which was where orders were followed because subordinates recognised the legitimacy of those giving the orders. He wrote about rational-legal bureaucracy as one of three pure or 'ideal' types of social authority, the other two being charismatic leadership and cultural tradition.

However, Weber's views about the process of bureaucracy and his views about its effect upon society were antithetical. He held that bureaucracy was both necessary in order to achieve rationality, and therefore equity, in social affairs and simultaneously dangerous in that it stifled just the kind of charismatic leadership which was needed for institutions to respond to social change. Within the Weberian rational-legal bureaucratic model, hierarchical structures of command are created which act independently of government itself. This prototype civil service was envisaged as being composed of a non-hereditary elite that would strictly implement the law (or the rules of an institution) without ever allowing personal feelings or motivations to impinge upon this process.

Weber's construction of rational-legal bureaucracy implies that there should not be any inherent difficulty in the translation of policy into action:

"In fully developed institutions the chances of implementing particular measures instigated by those in superior positions are optimal. They guarantee not only regularity and efficiency of operation, but above all rational implementation in accordance with the original aims of those who control them." (Mommsen, 1989, pp.113)

But since ideal types are not intended as a description of reality but merely as a means of analysing social phenomena, Weber does not aver that institutions will, in practice, operate in such a manner. Indeed, as other commentators have pointed out, for Weber:

"Social action is always probable rather than certain because the unique nature of social relationships generates the possibility of deviation from the expected course of action." (Swingewood, 1991, pp.146)

Despite this caveat in the original writings, Weberian ideas have often been used in organisation and management studies as though he had simply advocated bureaucratic hierarchies as the structure to which all institutions should aspire (e.g. Pugh & Hickson, 1996). The equally important negative factors which Weber rightly associated with bureaucracies are often overlooked, especially his belief that bureaucratic rationalisation would suppress individual creativity and so result in a system unable to produce leaders with flair or charisma. Critics of mainstream organizational theory have argued that:

"Many of the attempts to improve the performance of public agencies follow the logic of organizational studies, assuming that if management structures and processes, channels of communication and clarity of communication are 'right', effective action will be assured" (Barrett & Fudge, 1981, pp.9).

It was partly as an antidote to this continuing focus on rational managerial control that the body of work now known as implementation studies began to emerge.

Top-down theories of implementation

The first theorists to directly tackle the subject of public policy implementation were the Americans Pressman and Wildavsky, in 1973. The full title of their seminal text gives a fair indication of both the reason for their interest in the subject matter and what they were hoping to achieve:

“Implementation: How Great Expectations in Washington Are Dashed in Oakland; Or, Why It's Amazing That Federal Programmes Work at All, This Being a Saga of the Economic Development Administration as Told by Two Sympathetic Observers Who Seek to Build Morals on a Foundation of Ruined Hopes”

At the heart of Pressman and Wildavsky's theory is the belief that policy-making; policy implementation and policy evaluation are separate and distinct phases in the process of government. They, like others after them (e.g. Lewis, 1984; Hyder, 1984), choose to liken policy to a theory or hypothesis that must be tested by the process of implementation before it can be evaluated as a success or failure. This leads them to suggest that:

“Implementation may be viewed as a process of interaction between the setting of goals and actions geared to achieving them.” (Pressman & Wildavsky, 1973, p.xiv)

They then go on to argue that:

“Programs make the theories operational by forging the first link in the causal chain linking actions to objectives. Given X we obtain Y. Implementation, then, is the ability to forge subsequent links in the causal chain so as to obtain the desired results.” (ibid.)

In essence, Pressman and Wildavsky propose a model in which implementation is no more and no less than a causal chain of actions. For policy to result in the outcomes expected by its proponents there should be as few links as possible in the causal chain since, it is argued, each transfer of information and responsibility from one actor to the next will result in a slight mismatch of understanding and/or intent. The cumulative effect of mismatches in the policy chain linkage results in a difference between stated policy goals and actual policy outcomes, and is termed 'implementation deficit'.

This archetype has since been termed a 'top-down' model of policy implementation, in that it creates a hierarchy of roles and responsibilities in which politicians formulate policy and administrators implement it. Within this framework the implementation of any given policy by public administrators becomes largely a bureaucratic process of managerial control. Just as in Weber's construction of bureaucracy, the individuals involved in implementation are unimportant, other than as human resources, and are assumed to be both willing and able to set aside personal attitudes and emotions during their work. This may be achievable for policies which are concerned with relatively simple well-defined issues, such as the example given earlier of a change in the rate of income tax. However, such a complete degree of emotional detachment seems unlikely, and is perhaps not even altogether desirable, in the implementation of human services.

Aware of the pervasive nature of implementation deficit in public policy, subsequent advocates of this top-down model have attempted to define the conditions necessary for perfect implementation to occur. This in many ways mirrors the way economists create models of 'perfect competition' or 'pure monopoly'. In the case of both economic and implementation modelling, the theories appear to have face validity until it is realised that the conditions specified will rarely, if ever, exist in the real world (see Begg, Fischer &

Dornbusch, 1991, for mainstream economic theory; Holland, 1987, for an alternative viewpoint).

Hood (1976) was one of the first to attempt to outline a set of rules for creating the ideal administrative bureaucracy, under which perfect implementation could occur. He stipulated five key conditions that would have to be met:

- 1. A unitary administrative system with a single chain of command.*
- 2. Rules of the system to be fully understood by all officials and uniformly enforced.*
- 3. Perfect obedience/administrative control.*
- 4. Perfect communication and co-operation between each level of administration.*
- 5. No time pressure.*

(Hood, 1976, pp. 6-7, abridged)

The hope was that under such a system the likelihood of implementation deficit arising could be minimised.

Hood's model was later used by Gunn (1978) as the basis of a more prescriptive model. Gunn describes in detail the ten pre-conditions which he believes are necessary in order to achieve perfect implementation. The subheadings used to summarise each of the conditions are as follows:

- 1. That circumstances external to the implementing agency do not impose crippling constraints.*
- 2. That adequate time and sufficient resources are made available to the program.*
- 3. That not only are there no constraints in terms of overall resources but also that, at each stage in the implementation process, the required combination of resources is actually available.*
- 4. That the policy to be implemented is based on a valid theory of cause and effect.*
- 5. That the relationship between cause and effect is direct and that there are few, if any, intervening links.*

6. *That there is a single implementing agency which need not depend upon other agencies for success or, if other agencies are involved, that the dependency relationships are minimal in number and importance.*
 7. *That there is complete understanding of, and agreement upon, the objectives to be achieved; and that these conditions persist throughout the implementation process.*
 8. *That in moving towards agreed objectives it is possible to specify, in complete detail and perfect sequence, the tasks to be performed by each participant.*
 9. *That there is perfect communication among, and co-ordination of, the various elements or agencies involved in the programme.*
 10. *That those in authority can demand and obtain perfect obedience.*
- (Gunn, 1978, pp.170-174)

The problem with these models and other like them (e.g. Dunsire, 1978; Sabatier & Mazmanian, 1979; Mazmanian & Sabatier, 1989) is that they not only bear little relation to conditions found in the real world, but also make certain assumptions about the policy being implemented and the people who will implement it. Top-down models assume that policies will be based on valid theories of cause and effect, that the necessary resources will be available as and when required, and that all those involved at each stage in the implementation process will share common goals and ideologies.

Gunn acknowledges the debt that his approach owes to the principles used for economic modelling, and also concedes that the conditions which he sets out are never going to be found in real life situations. However, he argues that the point of his model and others like it is to provide a checklist against which the plausibility of implementing any given policy can be assessed. Applying such a checklist to the policy of care in the community for adults with learning disabilities it is immediately possible to predict that problems will arise during implementation. To take just two of the pre-requisites outlined by Gunn: community care policies are *not* based on any simple relationship between

cause and effect; and *two separate* organisations are charged with its implementation, the *National* Health Service and *Local* Authority departments of social services.

Although comparing Gunn's checklist with reality in the field is a useful exercise in so much as it indicates that community care policy is likely to experience a considerable degree of implementation deficit, it gives little insight into why this should be the case. Knowing the conditions in which implementation will occur it is possible to predict the likely outcomes of a policy and whether it will succeed or fail, but the reasons for this will remain elusive. In the case of community care this begs questions such as: **why** is co-ordination and co-operation between health and social services so hard to achieve? And **why** can service managers not demand and obtain perfect obedience from their workers? It was in attempting to explain such phenomena, and by doing so questioning the assumptions upon which the top-down models are based, that alternative approaches to implementation theory began to emerge.

Bottom-up theories of implementation

Bottom-up theories of implementation take as their shared starting point the belief that, in practice, policy and implementation cannot be separated.

Although all levels of public sector workers may be termed implementers, since they are charged with acting in ways determined by government policy, they are all also policy-makers. This combination of dual-purpose implementation and policy-making is most prevalent in human services, since these by their very nature result in a high degree of professional autonomy being delegated to frontline workers. Policy, in the bottom-up model, is crystallised in the moment at which workers come into contact with the public and must make life-changing decisions.

In addition to sharing a belief in the inseparability of policy-making from its implementation, advocates of bottom-up models challenge the assumptions that underpin top-down theories. In doing so their approaches vary, but the resulting theories have much in common. The two main assumptions which are challenged by these models are the beliefs that public sector workers can, or do, act rationally and dispassionately in carrying out their duties, and that elected politicians will necessarily base their policy ideas on valid theories of cause and effect.

Street-level bureaucracy

Michael Lipsky (1980; 1981; 1984) coined the phrase ‘street-level bureaucrats’ to describe those public sector workers whose role involves responding directly to the demands of service recipients. Police officers, judges, teachers, social workers and health workers all fall within this category, along with any other public sector workers who either determine access to state services or confer state-sanctioned status, such as ‘criminal’ or ‘learning disabled’ upon individuals. Unlike top-down theories, this approach blurs the distinction between policy and implementation, arguing that:

“Although they are normally regarded as low-level employees, the actions of most public service workers actually constitute the services ‘delivered’ by government. Moreover, when taken together the individual decisions of these workers become, or add up to, agency policy” (Lipsky, 1980, p.3).

Such an approach does not ignore the fact that formal policy decisions are made by government, or in the highest echelons of administrative organisations, but it does suggest that the nature of the work undertaken by welfare institutions makes it inevitable that working practices will *of necessity* devolve much power to street-level workers. And once power is spread

between many individuals in this manner it becomes considerably more difficult for those further up the managerial hierarchy to control.

With power effectively devolved down to the level of individual frontline workers it is impossible to expect managerial control to be absolute, or that each individual will always act consistently and rationally. Crucially, street-level bureaucrats' behaviour is shaped by the environment in which they work: an environment, moreover, that is typified in the public sector by chronic shortages of time and money. Since demand for public services increases with supply, (Lipsky, 1980 & 1981) and the public and political will to fund welfare services is limited, the pressure under which public sector workers find themselves working will rise inexorably. Under such circumstances workers must develop ways of coping, and often find that:

"The best way to keep demand within manageable proportions is to deliver a consistently inaccessible or inferior product." (Lipsky, 1981, p.22)

For this reason procedures which mitigate against client welfare may often become commonly accepted practice within publicly-funded human services:

"This means that social service agencies often present classic examples of 'goal displacement', that is, the substitution of the organization's bureaucratic needs for the original agency mission... .. The day-to-day objective of social service agencies becomes managing the caseload rather than providing the service" (ibid., p.23)

This suggests that, by their very nature, policies such as community care, which are concerned with the delivery of human services, can never be straightforwardly implemented in the manner proposed by top-down theorists. The essential difference between the two theoretical positions is posited on behalf of street-level bureaucrats by observation that:

"The reality of the work of the street-level bureaucrat could hardly be farther from the bureaucratic ideal of impersonal detachment in decision making" (Lipsky, 1980, p.9).

Such a model does not blame anyone, either collectively or individually, for creating 'implementation deficit' and views the divergence between stated policy goals and actual policy outcomes as an inevitable product of current bureaucratic systems. It also does not offer any easy solutions for changing current systems, arguing that:

"Significant changes in street-level bureaucracy are likely only to be realised in the context of social changes" (Lipsky, 1981, p.193).

It does, however, very clearly set out the reasons why people who formulate policy cannot and should not expect perfect obedience from those working at street level.

Lipsky's theory of street-level bureaucracy challenges the top-down approach to implementation on the basis that it makes false assumptions concerning the ability of workers to act 'rationally', and in accordance with bureaucratic regulations, in the provision of human services. Other bottom-up approaches, which share a common belief in the inseparability of policy from implementation, have chosen to question different elements of the basic premises that underpin the top-down models.

Action-centred implementation

In the UK, Barrett and Fudge (1981) have developed their own theories about implementation, which they have termed 'action-centred'. Like Lipsky, they challenge the notion that frontline workers in public services simply follow instructions from those further up the chain of command. However, rather than concentrating on the effect of service structures upon individual action, their analysis emphasises the need for interaction and negotiation during the policy process. They highlight the fact that:

“In many instances - especially in the public policy field - those upon whom action depends are not in any hierarchical association with those making policy. By definition, public policy is often aimed at directing or intervening in the activities of private interests and agencies. Implementation agencies will thus, in many instances, be autonomous or semi-autonomous, with their own interests and priorities to pursue and their own policy-making role” (Barrett & Fudge, 1981, p.12).

Drawing explicitly from earlier theories of both implementation and management, they go on to argue that the lack of an accepted hierarchy of powers between the multiple agencies charged with implementing public policy leaves negotiation and compromise as the only way of reaching decisions on action which will be accepted as legitimate by all involved. This, in turn, means that there will inevitably be a difference between original policy and eventual outcomes. On this basis, Barrett and Fudge question whether such a thing as an ‘implementation process’, moving smoothly and straightforwardly from policy to action, can be shown to exist in practice. They instead suggest that:

“Rather, it is appropriate to consider implementation as a policy/action continuum in which an interactive and negotiative process is taking place over time between those seeking to put policy into effect and those upon whom action depends” (ibid., p.25).

In the case of community care, this model makes it seem likely that much will depend upon the policy input of provider organisations, whose services are purchased with public money in order to provide care for those assessed as being in need. This poses several problems. Firstly, it is not easy for the public sector purchasers to ensure that such care will always be of the highest standard (Hoyes & Means, 1993). Secondly, previously independent voluntary organisations:

“May be forced to conform to standards imposed by contracting policy at the expense of their home grown notions of what constitutes effective service delivery” (Lipsky & Smith, 1989).

And, thirdly, the impact of contracting out public services may have multiple consequences for street-level workers, including reduced salaries and less job protection (Smith & Lipsky, 1993), which may in turn increase the prevalence of goal displacement (i.e. the tendency to replace the original aims of an organisation with that of fulfilling its bureaucratic requirements) and other potentially negative factors affecting implementation.

Evolutionary implementation

The final distinctive strand within bottom-up approaches to implementation theories is that of the evolutionary model. Like other bottom-up approaches this model assumes that changes will occur to a policy as it is implemented, and it is again regarded that such changes are not necessarily a bad thing. However, rather than typify the changes as either implementation deficit, goal displacement or the result of open debate and compromise:

“The evolutionary model emphasises the progressive modification of policies, largely in response to environmental factors” (Lewis, 1984, p.206).

In practical terms, this model assumes that bureaucratic working practices create an environment which is resistant to change and in which the power of managers to force through changes is equal to, or less than, the power of other individuals or groups to desist. Thus:

“Policies are changed to fit the needs and standard operating procedures of the agencies and individuals that carry them out. They are implemented so as to produce as little disruption as possible to existing agreements, coalitions, power, and status in an organisation.

This almost invariably requires many adjustments in the policy during the process of implementation” (Palumbo & Harder, 1981, p. x).

The reason for such behaviour upon the part of lower-level implementers is due in large part to the fact that the different individuals and groups involved in implementing any given policy are likely to have different values, motivations and expectations. In summary, these differences amount to separate and distinct ideologies, which may be conflicting. It is relatively easy to obscure such ideological differences in obfuscatory language at the policy-making stage, but they will undoubtedly re-emerge as policy is translated into action. The observation by Lewis that:

“The ambiguities of political language reflect the difficulty of obtaining agreement on policy between conflicting and competing interests, especially when a number of parties are involved. It is no accident that, in reports of committees, the crucial passages are often written in an obscure and Delphic way” (Lewis, 1984, p.206)

Could easily be taken to refer directly to community care. The ideological differences between medical and nursing professions on the one hand and the social work profession on the other are ignored in a policy which blithely demands that a distinction be drawn between health care and social care, but chooses to leave the mechanics of such a distinction to its implementers.

Implementation as politics

Barrett and Fudge also, in common with a number of other writers (e.g. Hill, 1981; Ham & Hill, 1984; Lewis, 1984) view implementation as part of a continuing political process. Whereas, in the top-down view, policy-making is a legitimate enterprise only when undertaken by democratically elected representatives of ‘the people’, the bottom-up approach tacitly acknowledges a broader base of legitimate interests. While the top-down case rests on the

constitutional principle of separation of powers (see Hampshire-Monk, 1992), the bottom-up approach is more pragmatic: it embraces the possibility that even if the legislative function of government could, in practice, be fully and clearly separated from the executive function this would not automatically guarantee that the interests of all sections of society will be considered. Thus, in a political sense, top-down models uphold the traditions of liberal democracy, whilst bottom-up models recognise that, in modern societies, there may be groups who are excluded from formal politics and are only able to exert influence during the implementation process. That is not to say, however, that changes which occur to a policy during its implementation necessarily represent a victory for the underdog, since powerful alliances of professionals (e.g. medics, lawyers) or business interests may also find it advantageous to try to influence policies during this part of the cycle.

Staying within the political sphere, Ham and Hill (1984) question the basis upon which politicians make policy decisions. They argue that policies which ‘fail’ are seldom straightforward cases of implementation failure in the traditional sense. Firstly, policies may be based on false assumptions about cause and effect, a key cause of implementation failure recognised by top-down models, and one of the areas highlighted in each of the models for perfect implementation. Secondly, the complexity of a policy may make it difficult to define specific goals related to such a policy. This, in turn, will make the policy extremely hard to evaluate since there are no objective criteria against which implementation success or failure may be measured. From this, Ham and Hill go on to suggest that:

“The argument so far has been that implementation studies face problems in identifying what is being implemented because policies are complex phenomena. We want now to go a stage further and suggest that perhaps they are quite deliberately made complex, obscure, ambiguous or even meaningless” (Ham & Hill, 1984, p.102).

Ham and Hill term such deliberately ill-defined political promises ‘symbolic’ policies, and suggest that these add illegitimately to perceptions of policy and implementation failure because they were never actually intended to be put into action. The value of such policies for politicians is that they can act as a kind of campaign shorthand to indicate a quality, such as concern for poverty or wish to uphold law and order, but blame can be deflected elsewhere if change fails to materialise. And this phenomenon can happen elsewhere in the cycle, other than merely in party manifestos or election promises:

“In Britain, for example, many regulatory policies require parliamentary enactment but local authority implementation. The former may relatively easily pass laws allowing the control of certain activities or the provision of certain services whilst not providing the resources to make action possible” (ibid., p.103).

Many, if not most, areas of public service have suffered to a greater or lesser extent from this kind of resource shortfall and community care is no exception (Means & Smith, 1994; Lewis & Glennerster, 1986). This makes it inevitable that degrees of purported implementation deficit will occur, since actors lower down the administrative hierarchy must decide where to cut corners, or which elements of the original policy to ignore.

A further twist on the manner in which politicians use symbolic policies to their own advantage is offered by Sabatier (1986). He acknowledges the complexity of much government legislation and uses this as the basis for demonstrating how this sometimes provides politicians with useful camouflage. In his analysis of events a distinction can be drawn between ‘core’ and ‘non-core’ elements of policy, the core elements being those which are of primary importance to the government and the non-core elements being those regarded as optional, or at least less vital. However, it may be useful for those in power to be somewhat economical with the truth in relation to the aims of certain policies. In such cases politicians may choose to sell a policy to the public by emphasising the non-core elements and playing down their core intentions.

Lewis and Glennerster (1986) use the core/non-core analogy to explain some of the difficulties experienced by those implementing the community care element of the 1990 National Health Service and Community Care Act. They argue that, throughout the 1980s, the three overarching aims of the Thatcher government had been to cut public expenditure, to encourage private enterprise and to limit the power of (Labour-dominated) local authorities. To further the second and third of these objectives, the government had in 1982 changed social security benefit rules so as to extend supplementary benefit payments to people living in private residential care homes. Presented as promoting 'individual choice' for those requiring care, the policy also had a clear subtext of promoting private enterprise in the public-service dominated field of care provision and reducing the budgets, and hence the power, of the local authorities who had traditionally provided the majority of this type of care.

Implementing changes in social security benefit is a relatively straightforward process, so the policy rapidly began to have an effect upon residential care provision. Private care homes were no longer the sole province of the rich, but could be accessed by anyone entitled to claim the new supplementary benefits. The market for private residential care expanded rapidly. Between 1979 and 1990 places in private residential care homes for the elderly, and for people with physical or learning disabilities rose by 130% (Walker, 1993). Such a huge uptake of the new benefits had not been foreseen by the government, who became concerned at the implications this policy was having upon their core objective of reducing public expenditure.

It was into this political and economic climate that plans for the NHS & Community Care Act were launched. The government was keen to be seen to continue to promote both community care and individual freedom of choice, but was equally determined to keep a firm grip on the costs involved. The changes that the new Act would introduce were aimed at continuing to actively promote community and choice, but at less cost to the exchequer. In effect,

what the legislation did was to limit the finances available for this area of public policy by transferring (some) money and (all) responsibility for community care services from the social security budget to local authorities. To ensure that power was not simultaneously returned to local authorities alongside their newfound responsibilities, money was only made available to pay for community care services on the proviso that at least 80% of it was spent on purchasing care in the independent sector.

Applying Sabatier's principles to the proposed legislation, Lewis and Glennerster:

“... hypothesise that the government would try to ensure that it won on expenditure {core}, compromise slightly on the purchaser-provider split {near-core}, but leave the care management issues {non-core} more open to local determination” {addition to original text} (Lewis & Glennerster, 1996, p.19).

This, indeed, seems a fair analysis of what happened. The government was able to win on its core policy objectives because it was able to sell the policy to public and professionals alike on the basis of non-core attributes. From a street-level perspective the policy was broadly welcomed as promoting needs-led services that would, in theory, be more responsive than previous care systems to individual needs. From a central government perspective this policy also had the additional benefit that local government would implement it, and hence it was likely that blame for any possible implementation failures could also be kept at arms length.

Bearing all of the above ideas in mind, this study therefore seeks to examine which of the existing theories of implementation best explains the chasm evident between community care policies as espoused by successive governments and the actual provision of services to individuals with a learning disability. In doing so, an attempt will be made to distinguish between those implementation difficulties which are created by government structures and

actions (or inactions) and those which are created by local organisational structures and local actors.

Chapter 4

Methodology

Research aims

All statutorily provided health and social care services are in essence local interpretations of the same national government policies. Individual entitlement to such community care services is ostensibly based entirely on dispassionate professional assessments of individual need. Despite this, commentaries based on financial analysis have suggested that there is a less than equitable geographical distribution of community care services (e.g. Davies & Knapp, 1994; Evandrou et al, 1995). Services for people with learning disabilities come under the umbrella of adult community care provision. They, too, vary a great deal across the country in terms of both scope and quantity (Turner, Sweeney & Hayes, 1995; DoH 1992 & 1995). Since all learning disability services share the same basic statutory framework it is logical to surmise that the inequitable outcomes are the result of local variations in the implementation of national policy. This research therefore sets out to explore the reasons why community care policies for adults with learning disabilities have proved so difficult to implement in a consistent and equitable manner.

Within this broad context, the emphasis of this research has been directed towards an examination of the factors contributing to the multiple eventual outcomes of official national policies. Through the close inspection of the practices, attitudes and beliefs of those working in the statutory learning disability sector it is hoped to determine the reasons why inequitable variations in service delivery occur. In particular it is hoped to shed more light on the relationship between health and social services and to assess the impact that this has upon policy implementation.

Choice of research methodology

In approaching a subject matter of such complexity it was felt from the outset that a qualitative methodology, and hence a phenomenological rather than a positivist approach, would provide the most suitable philosophical underpinning (Maykut & Morehouse, 1994). It was hoped that this stance would enable the collection of 'rich' data with which to explore the relevant issues and would avoid limiting the potential scope of the research to the horizons proscribed by the a priori ideas of the researcher (Cassell & Symon, 1994). Quantitative measures were felt to be unsuitable not simply due to the inherent difficulties in choosing and defining suitable outcome measures, but because what was being examined were human interactions rather than discrete actions.

The methodology adopted was informed by a number of different qualitative approaches, but design flexibility was given a higher priority than slavishly following any one system of data collection and analysis (Marshall & Rossman, 1995). Within this, the most significant influences were those of grounded theory (Glaser & Strauss, 1967) and discourse analysis (Potter & Wetherall, 1987). It is important to note, however, that these texts were both used to provide theoretical methodological insights rather than as full research methodologies in their own right.

Grounded theory was relevant in as much as it stresses that an iterative process is at work in which researcher and participants create a shared understanding of the phenomena under examination. It was also useful in its promotion of the concept that social research is best approached with an open mind and without a commitment to proving or disproving any one theory. Grounded theory purports to espouse the belief that it is possible to approach a research subject

without any a priori beliefs or expectations. This idea, that any researcher could be capable of approaching their work wholly without preconceptions, was rejected, since an interest in any particular field of enquiry must logically entail some small amount of knowledge of the subject and hence engender an outlook already shaped by this knowledge. Despite this reservation, the belief that the researcher should be as open-minded as possible remained central, and the idea that theory should be generated from the data (rather than imposed upon it) was embraced.

Similarly, a broad appreciation of discourse analysis was useful in as much as it placed the focus on words, as spoken in interviews or written in official documentation, and gave an understanding that the 'reality' of a policy or situation may vary according to the perceptions and understandings of the speaker. This approach helped in analysing interview transcripts where contradiction and divergent views were commonplace, valuing the wide range of 'interpretive repertoires' that this afforded. It was also important in so much as it laid emphasis on the idea of reality as a social construct that varies according to the individual experiences, whether professional, personal or socio-cultural, of each interviewee. However, the extreme social constructionist position, which relativises and 'ironises' all language was rejected, since this would imply that no words can ever be taken at face value.

In the past, some commentators have viewed grounded theory and discourse analysis as antithetical. More recently, however, there has been a recognition that the two methods could productively be remodelled to work together (Pidgeon, 1996) and a number of studies pertaining to a diverse spectrum of human relations have openly combined the two approaches (e.g. Henwood, 1993; Lugton, 1997; Willot & Griffin, 1997).

At the start of the research process the position taken can best be summarised by quoting Maykut & Morehouse (1994, p.33) who said:

“In order to understand a person or a phenomena, one needs to understand the context that surrounds the person or phenomenon. The naturalist enquirer does not know directly what he/she is looking for at the beginning of a research project because he/she does not know the context”.

Within this broad phenomenological epistemology, the research developed into what could be termed case studies (Robson, 1993) of the statutory health and social care services for adults with learning disabilities in two distinct geographical areas. Adopting a case study approach was in part a pragmatic decision, since repeating such a lengthy investigative process across a representative sample of study areas would have been impossible within the time available. However it was felt that repeating the process in two study areas, rather than limiting the research to a single location, could provide a greater insight into the relevant issues. Specifically, it was hoped that examining the similarities and differences between the two study areas would make it possible to say, with a greater degree of certainty, which factors affecting implementation were created by local circumstance and which could be credited to national policy.

Dialogue was entered into with a number of health trusts and social service departments around the country in order to establish whether there were any set patterns regarding the provision of learning disability services. No rational means of categorising the different structures could be identified, especially as the situation in many areas was in a state of constant flux. Area A was therefore chosen purely on the basis that it was the first area where permission to undertake the research was granted by both health and social services. Area B was subsequently selected on the basis that it was located within a different Regional Health Authority and, unlike area A, it did not have a long-stay hospital.

Data collection

Prior to the start of the data collection process ideas about the research topic were generated in a number of ways, including seminar discussions within the university; attending conferences; sitting in on a Department of Health discussion group; and informal interviews with learning disabilities staff from various services. This helped in the formulation of the original interview outline used, but this was continually modified in small ways as the data collection progressed and the questions listed in Appendix I are representative rather than definitive.

The majority of data collected was transcripts of semi-structured interviews conducted with staff from health and local authority services for people with learning disabilities. In addition, facts concerning the managerial structure of organisations were gathered from both individual interviewees and public information brochures produced by the organisations concerned.

Those chosen for interview were a purposive sample (Robson, 1993: p. 141) of employees, ranging from the most senior learning disability manager that each organisation had to offer, through to community nurses and social workers in Community Learning Disability Teams (CLDTs). The organisational charts in Appendix II show the position of interviewees within the structure of their organisation. In area A interviews were also conducted with both Consultant psychiatrists specialising in learning disability and with senior clinical psychologists, since both of these professions played an active role in shaping local services. Neither psychiatrists nor psychologists were approached for interview in area B because here their role was clearly limited to that of clinical input to individuals. Overall, the selection of interviewees was made on the basis of attempting to gain as great a breadth of opinion as possible from staff working at different organisational levels within both health and social services.

No interviews were conducted with staff from residential, domiciliary or day services for people with learning disabilities in either area because their role was felt to be less relevant in the terms of this research. Those interviewed were chosen because they were in positions which, to a greater or lesser extent, involved making decisions about the distribution of services and resources, and as such their role entailed some degree of interpretation of policy. This meant that therapists (e.g. occupational therapists, speech therapists and physiotherapists) were also excluded on the basis that their roles did not include holistic assessment of client need or determine access to other services.

In each of the five organisations (two health trusts and three social service departments) that took part in the research, the most senior learning disability manager was interviewed first. At the end of this interview, having also asked this person to provide details of their organisational hierarchy, other pertinent interviewees were identified. Thus a cascade principle was used to identify interviewees down to the level of CLDT manager. In area A, the senior community nurse provided names and contact details of community nurses in each of the CLDTs. When CLDT managers in area A were interviewed they then asked social workers from their team to volunteer to be interviewed. By contrast, in area B the CLDT manager provided a list of nurses and social workers who could be contacted. Of these, one nurse declined to be interviewed on the basis that his wife had recently given birth and he was too busy, but he suggested a colleague who was happy to participate in his place.

When interview appointments were made, the nature of the research was briefly explained, i.e. that it was a study concerning the provision of learning disability services in the area by both health and social services. With the exception of one community nurse in area A, who chose to come to the university to be interviewed, all interviews were conducted in private rooms at the interviewee's place of work. At the start of each interview the interviewee

was assured of confidentiality and was asked for their consent for the interview to be recorded.

Interviews were semi-structured, based around a set of open-ended questions (Appendix I) that had been tailored beforehand to be of relevance to the position of the interviewee. The majority of questions asked were common to all interviewees, but a few were job-specific. For example, everyone was asked to describe working relations between health and social services in their area, but only those from CLDTs were asked to explain how the role of the social worker differed from that of a community nurse in their team. The aim was to make interviews a conversational rather than an interrogative process, and as each progressed there was opportunity to develop a dialogue about areas of particular interest or concern to the interviewee. Topics covered during interviews included questions about the interpretation of central government policies; local working practices; relations between health and social service organisations; and the extent of any collaboration across service boundaries.

Interviews in area A were conducted between June 1998 and August 1999, whilst those in area B were conducted between September 1999 and February 2000. In all, thirty-two interviews were conducted, each of which lasted from between forty-five minutes to an hour and a quarter.

Data analysis

All interviews were transcribed in full prior to analysis. This resulted in a body of data which comprised over 210,000 words.

The mode of analysis used to examine the interview transcripts is best captured by the description 'thematic content analysis', as outlined by Burnard (1991). Essentially, the methodologies of grounded theory and discourse analysis have been brought to bear sequentially upon the data. Grounded theory techniques were used initially to summarise each segment of transcript, and thus to generate coding categories. In this sense the categories are grounded in the data gathered at interview.

The actual analysis began with transcripts which had been printed out in a single broad column down the left hand side of the paper, leaving the right hand side blank for note-taking. The first half-dozen transcripts were then read and re-read several times, in a process described by Burnard (*ibid.*) as 'immersion' in the data. The process of coding then began, with categories generated directly from the text. For example, here is a brief extract from an interview with a community nurse:

Transcript

Coding

I certainly feel I have a good working relationship with colleagues in Social Services erm... and... you know, sort of respect the work that they do. And I've found that the cases that I work jointly with a social worker and with other members of the team are almost always the most satisfactory and always the ones that we get the best results on.

Co-operation in practice

Team issues

Unfortunately erm... we're not always able to jointly work with clients because... you know, there is a lack of resources or because it may not be indicated that that person... you know, a person does not necessarily have to have a social worker just because they have been referred to our team.

Financial issues

Team issues

When this process had been repeated with a number of complete transcripts the coding categories which had been generated were written in bold marker pen onto index cards. From then on these categories were used as the basis for coding all further transcripts. The initial list of categories was amended several

times during the ongoing coding process, as and when later interviews yielded categories not found previously. Having thus generated a set of flexible categories, each transcript was coded, using the space available in the right hand margin. Excerpts of coded transcript were then cut from the main transcript, pasted onto index cards and filed under the appropriate category. Each card was marked with the initials of the interviewee and the page and line number at which the quotation started. This was done in order to prevent quotes from becoming disassociated from the context in which they were originally spoken. For the same reason a complete copy of each transcript was also maintained.

By the time every interview transcript had been fully coded in the manner described, the following categories had emerged:

- Assessments
- Central government and legislation
- Client and carer issues
- Co-operation in practice
- Defining the boundaries
- Examples of dispute
- Financial factors
- Historical factors
- Human interaction and personality
- Ideology and culture
- Management issues
- Medic and Councillor influence
- Organisational structures
- Private and voluntary sectors
- Referral criteria
- Role definition
- Skills and expertise
- Team issues
- Unmet need

It is important to note at this point that two copies of each transcript were used during the coding process. This meant that, where necessary, excerpts could be coded under more than one category. For example, the same interviewee as quoted above also said:

What happens when you're under stress is,
rather than looking at the system that's
creating that stress for you, what you do is...
you know, you... you lash out at people who
least deserve to be lashed out at.

This was coded twice, under the categories of both 'organisational structures' and 'human interaction and personality', since it was of relevance to each. Unlike grounded theory, which stipulates that only the first example of a particular viewpoint need be processed, in this method of analysis every interview transcript was coded in full. This made it possible to examine not only whether many interviewees had shared a particular view, but also how certain views were distributed amongst the different professional groups. For example, it was possible to examine whether health staff or social service staff found central government guidelines on continuing care most useful. Or to explore whether frontline staff, such as social workers and community nurses in CLDTs, were more positive or less positive about collaboration between organisations than were senior managers.

Manual coding was chosen in preference to the possible use of computer-based qualitative data packages, such as Q-nudist, for a number of reasons. Firstly, the slow speed at which manual coding progresses was useful in that it encouraged immersion in the data. Secondly, this slowness made it less likely that significant concepts would be overlooked. And, thirdly, having each excerpt physically available on an individual card index made it easier to sift and sort variations found within each category and so assisted hugely with the eventual process of writing up.

When all coding had been completed, the list of categories generated was studied so that they could be ‘collapsed’ into a much smaller number of ‘themes’ (Burnard, *ibid.*). From this point on the concepts embodied within a discourse analytic approach came to bear more heavily upon the process. Examination and re-examination of the coded data was undertaken in order to identify emergent themes. The three themes which became apparent during this process were:

1. Service structures
2. Individual, professional and ideological influences (a.k.a. ‘human factors’)
3. Interpretation of policy (a.k.a. ‘implementation’)

Once this set of three themes had been developed the analytic methodology become more explicitly recognisable as a form of discourse analysis. Each theme, in turn, was stringently examined in order to pick out, compare and contrast the different ways in which interviewees had chosen to express themselves upon the issue. From this a thesis concerning the factors affecting local implementation of national learning disability policies began to develop.

Chapter 5.1

Analysis of data

The analysis of interview data will be built around the three themes that emerged, of organisational structures, human factors and interpretation and implementation of policy. Each theme will be examined in turn, and each of these three sections will follow the same sequence of first looking at evidence from area A, then at evidence from area B, and finally comparing the findings from each of the two areas.

Demographic and historical factors

The coding and analysis of interview data from the two research areas gave rise to much information of a subjective nature, and yet more which was an inseparable mixture of objective fact and personal opinion. Before starting on the description and analysis of these complex interwoven strands of information, however, it is useful to set out some less ambiguous facts that are of relevance.

First, a small amount of demographic information about the general population of the two areas will be presented. These statistics were obtained from the most recently available census reports. It is worth noting that these figures should be regarded with some caution. Not only is the 1991 census (Office of Population, Census & Surveys, 1992) now a decade old, but there are also considerable concerns as to the accuracy of the census information collected that year, due to large number of people known to have been avoiding all official evidence of their existence in protest at the introduction of the poll tax.

For this reason, the figures given should be regarded as useful for purposes of comparison between the two research areas, but may not have independent validity.

A further difficulty with using data from the census is that it is compiled and presented as statistics relating to local authority geographical areas. All data concerning area A are therefore only available in four separate constituent parts: i.e. separate figures are given for the City Council area and each of the three County Council Districts. For this reason demographic data which are given in relation to area A as a whole will be presented as a range of figures.

Area A had a total population of some 571,632 individuals. Of these, some 262,235 lived within the boundaries of the City, at a density of 35.3 per hectare. The District Council populations were variously 105,418 (population density 13.2); 108,038 (population density 9.2); and 95,941 (population density 2.4) and so represented demonstrably more rural areas.

Area B had a total population of 450,708 and a population density of 12.5 persons per hectare. It constituted a single metropolitan council area, comprising a city centre and outlying semi-rural areas.

The two areas were broadly comparable in terms of basic economic indicators such as rates of unemployment and owner occupation. However, there was considerable variation across the constituent elements of area A with regard to these indices.

The male unemployment rates in area A ranged from a high of 16.1% in the city, down to 7.3%, 7.3% and 5.9% in the districts. Female unemployment in area A ranged from 7.0% in the city to 6.2%, 5.8% and 7.9% in the districts. Area B had a male unemployment rate of 11.65% and a female unemployment rate of 5.85%.

Owner occupation varied in area A from just 51.9% in the city, which had a very large student population, to 77.7%, 81.0% and 79.3% in the districts. The rate of owner occupied housing in area B stood at 71.2 %.

The ethnic mix across the areas was complex. Area A's city population was 89.2% white. The main ethnic minority populations within the city were black-Caribbean (3.2%); black – other (1.2%); Pakistani (2.6%) and Indian (1.8%). The districts were from 97.6% to 97.7% white, and no individual ethnic minority population reached 1% of the total population. By contrast area B's population was 84.4% white. There was no significant black population, but Pakistanis accounted for 9.9% of the overall population of the area and Indians a further 2.6%

Secondly, the information that this type of research provides can be regarded as a snapshot of organisational structures and inter-organisational relationships at a particular moment in time. Since, like the policies that have shaped them, organisations cannot be understood separately from their past, it is important to understand something of the history of learning disability services in each area.

Area A had been in the vanguard of the national move towards community-based care for people with learning disabilities. Their long-stay mental handicap hospital had been closed in the late 1970s, and the local social services had been amongst the first to develop Community Mental Handicap Teams (CMHT), which were later renamed Community Learning Disability Teams (CLDT). However, this impressive forward-thinking had since stultified and it was also plausible that inter-organisational relationships had suffered due to the fact that major developments had been undertaken unilaterally by health and social services, at a time when central government exhortations to work collaboratively were still in their infancy. Thus, the large, isolated Victorian mental handicap hospital had been replaced by a more modern, low-rise hospital with good local transport links. Nevertheless this

new hospital was still home to over a hundred permanent inpatients and remained at the heart of health's learning disability provision at the time the research was undertaken. Social services in area A had maintained their basic structure of CLDTs, but other organisational structures had changed around them. Most importantly, in 1998 a unitary authority had been introduced which covered only the City population, and left the remainder of the (County) area still operating under the previous district council/county council two-tiered system. The role of the CLDTs had also changed significantly since their inception. They had originally been set up as specialist social work teams whose remit was to develop new and innovative services for people with learning disabilities, whose ongoing social work needs would continue to be met by general adult social services. However, over time and due largely to financial pressure these teams had transmogrified into the more traditional assessment based enterprises envisaged by the Community Care legislation.

Area B by contrast had been much slower to move towards community based services. The old long-stay mental handicap hospital did not close completely until 1992, although much resettlement had been undertaken in the years immediately preceding the Community Care Act's implementation in order to maximise social security funding for individuals receiving services. Because of its timing, the community reprovision of hospital services had had to be undertaken in conjunction with the local social service department and this necessity to collaborate had jump-started a previously non-existent relationship between health and social services. The CLDTs in area B had been instituted during this period, but although operational practice had changed over time, their overall remit of assessment had remained relatively unaltered.

Chapter 5.2.i

Organisational structure of services

It is necessary, in the first instance, to examine the structural frameworks within which each of the statutory organisations responsible for learning disability services in each study area operate. Official flow charts give some idea of how individual organisations are run, but they cannot reveal the whole picture. In order to obtain a fuller understanding of how such structures affect service outcomes it is also necessary to examine how individual organisation's structures enable or inhibit co-operation with other agencies. This will include an analysis of the prevailing flows of authority and responsibility; powers beyond the basic organisational structure; an examination of where and by whom decisions are made; the structure and functioning of Community and between services.

Health services - area A

The basic structure of health services in area A was relatively straightforward (see figure 1, appendix II). Senior staff roles were divided along the lines of operational services and there was a clear chain of command leading downwards from the Clinical Director. It should, however, be noted that whilst the Clinical Director played an important role in service planning and strategy this work was done in conjunction with purchasers from the Health Authority who retained ultimate control over budgets. Senior managerial and clinical staff were all based within the hospital grounds, most of them sharing offices in the same building. This simple fact of geographical proximity was felt to provide some organisational benefits in comparison to other local agencies:

“I mean, for me, you know, everybody’s in one place. My line manager and my directorate manager, they’re all in the same place, I have access to them all the time. Erm... I think in social services they’re so dispersed and fragmented that they don’t have that.”

With the advantages of a straightforward line management system and single management location, the main difficulties with the structure of health services in area A seemed to stem from two causes. The first was that community-based health services were, by and large, managed from the hospital site. This at times led to friction between the differing needs and expectations of hospital and community-based staff:

"I think you do get clashes of culture, but I think with the health staff that work with the Community Learning Disability Teams they will clash as much with the hospital site's culture as some of their social work colleagues."

One senior manager, who had a nursing background, stressed the importance of carefully defining the hospital's role within the overall spectrum of local services:

"Because it's such a huge site people are thinking 'it's a safety net'... and it isn't... it isn't a safety net, it's a treatment and therapeutic service."

The other, more serious, problem arose from the fact that medics operated outside the formal management hierarchy. Because area A's health services were still dominated by a long-stay hospital of roughly one hundred beds, there was still a sizeable team of specialist learning disability doctors working within this facility, headed by three consultant psychiatrists. One community nurse described local services as having:

“... still got very largely a medical model within *****, especially still having a hospital base and a lot of consultants. I think there is still a very much... a medical model very evident here”

But whether the continued existence of the hospital perpetuated the role of medical doctors in determining service priorities or vice versa was hard to tell.

Whatever the genesis of this ongoing dynamic, the power of consultants to shape service developments in area A was widely recognised. Consultants themselves believed that the nature of their role within services was changing, but did not perceive their powers as having been diminished by the service reconfigurations of recent years:

“It’s difficult... I mean, in some ways we lost because social services became the lead agency. So therefore people got taken out of our remit, who perhaps shouldn’t have been there because they didn’t have health problems or psychiatric problems. Erm... so if you talk in terms of power, in terms of people... number of people over whom you’ve had power, we’ve got a lot less. But on the other hand unless you had purchasers who were particularly er.. who had a particular direction in respect of the service, you could actually drive the purchasers. I think that’s our... I think that’s our local experience.”

This belief was also borne out by comments from senior social services staff:

“Well, I’m not sure whether we have entirely moved things away from the medical model. But I think the medics are quite keen, in some senses, to... move away from the medical model.”

“Two years ago if you’d have talked to psychiatrists at the hospital... you know, suggested that perhaps they’d got too many beds, then you have been erm... riots. And now they are closing beds and saying ‘Yeah, well, we don’t need all these’.”

With the advent of multi-disciplinary teams, the clinical role of the consultant had become one which commanded less absolute power than was the case in hospital settings. Consultants themselves recognised this as being a positive development:

“I don’t think less involved, I think it’s less influential. I mean... I think the problem is at a multidisciplinary level. Erm... I think that the role of a consultant is within the... the team. I think... I mean, gone are the days just because a consultant says something it has to happen. I

think erm... having a debate, having a discussion is much more useful for... for the clients and their families. And I think that the role of a consultant is providing expert help in this... in his or her field of knowledge, that's in psychiatry and also issues related to psychiatry."

But this apparent change in the consultants' clinical working practice was not paralleled by any diminution of their influence within the higher echelons of the local health service:

"The local consultants are very key in terms of determining the Trust strategy around learning disability. Erm... and obviously are influential in terms of shaping social services and other agency's plans as well. So I think we are quite... quite important."

"Gained or lost influence... I think it would be easy to say 'Oh well, we've lost influence' in the sense that of erm... often things like discharges and access to services do appear more constrained. On the other hand I think that in some ways that probably isn't true though, in that even though people... it may be more difficult to get people into services and whatever, but often people do ask for a clinician's perspective and often that's a medical perspective. And so in that sense there is still a strong element that medics within the service, certainly locally, do influence local service development quite considerably."

"I don't think we see it in terms of power-broking, I think we see it in terms of trying to mould the service so it works. So it probably... it could be perceived as us gaining power but it's because, I think, we've got things to say that people want to hear."

Officially the managerial responsibilities of consultants had been reduced over recent years. Speaking to the consultants this change would appear to be the result of choices they themselves had made, rather than the result of managers seizing power from them:

"As the three psychiatrists have put forward a lead clinician, we've decided that we didn't want to take over the management within our directorate because of other management issues that are not directly

relevant to us. Er... so we have a model of the Lead Clinician and Clinical Director. And the Lead Clinician and Clinical Director work together into the purchasers, into joint agency working and, partly depending on the dynamics, but in effect the most experienced people there are going to be the consultants.”

And the introduction of managers into health services was welcomed.

“Well locally it’s been positive. Erm... I think they’ve bought in... because, in a way, a medic can only do what a medic can do. You don’t really understand what... what happens at the direct carer interface.”

However, the positive spin given by consultants to their position of influence was not shared by all of their colleagues in either health or social services. One social work manager put the situation bluntly:

“And I suppose the question I’d ask is erm... and I know I asked this when I first came into the service, ‘How many medics do we need?’”

Another worker, who was anxious not to be identified, had more specific concerns over consultants’ roles:

“Health clinicians aren’t supervised by anybody. And they’re doing complex therapeutic work for which almost every other professional therapist would actually have a very structured process of supervision. I find it worrying. I mean... I mean... you know, I am worried about it. So senior clinicians now don’t have developed systems of accountability and supervision, both for management and/or clinical work, because there is a feeling that when you get to a certain level you are then totally autonomous. Which I think is very worrying.”

Whatever the factors which had served to create and maintain the power play evident at the heart of area A’s health service management, the facts remained that consultants did wield considerable power and that they do so from a position outside the formal managerial hierarchy. One senior non-medic talked of:

“How very subtly, and not always very subtly, general managers are made to feel in the ‘one down’ position.”

This undoubtedly caused a degree of friction at times between senior health service personnel. However, in terms of service outcomes, the effects of this ‘power outwith the structure’ were visible most keenly within the CLDTs. Consultants, perhaps unwittingly, contributed a great deal of friction to the operation of these social services-led multidisciplinary teams. This was because consultants often used their position to bypass the usual client referral procedures and so gain direct access to the services of community nurses. This problem will be explained more fully in the later section which deals with the structure and functioning of Community Learning Disability Teams in area A.

Social services - area A

The overall complexity of learning disability services in area A had been considerably increased since the implementation in April 1998 of local government restructuring, following the Whitehall-led Local Government Review (LGR). This meant that all Local Authority services, including social services, had been reconfigured along new administrative and geographical boundaries. Area A’s local government had been split into a unitary City Council on the one hand and a two-tier County and District Council structure on the other.

The immediate effect of these changes was not positive:

“I think at the moment it’s just led to planning blight because nobody’s in a safe job”

And this, in turn, had negatively affected relations between local health services and the two new social services departments:

“Loads of the very senior people have left and become more senior people elsewhere. And it’s just the haemorrhaging of anyone that we

used to do arrangements with. So it... it becomes managing short term and very, very problematic.”

In the wake of the LGR, City and County social services had adopted very different organisational structures (see figures 2 and 3, appendix II). Within City social services there was a single Head of Learning Disability Services, who had full responsibility for all operational services and also provided the main focus for learning disability input into strategic planning. This structural simplicity was appreciated by senior health personnel:

“There’s a feeling that City social services are kind of more go-ahead in the sense that er... they seem to have a person managing them who is more active, who’s wanting to change things, who is about creating sort of difference. And also it’s a more unified management structure, so basically key people oversee all the service rather than bits of it. So it’s much... it should be easier in the long run to get greater service coherence because all elements of the service, day and residential erm... fieldwork, are all under the same umbrella.”

By contrast, the structure of County social services was much more complex. Below the level of Director the service had been divided into sectors according to management function, rather than along the more traditional divisions of client group or operational services. This had resulted in services for people with learning disability being the partial responsibility of three out of the existing four Assistant Directors. Residential care services were the responsibility of the Assistant Director (Resources); CLDTs were the responsibility of the Assistant Director (Operations); and the commissioning of learning disability services from provider organisations was overseen by the Assistant Director (Commissioning – Adults).

It was not surprising that some people found the structure of area A's County social services hard to fathom. These two comments from a consultant were typical:

“ County feels diffuse, erm... fine within the individual Districts, but if you need something that needs a higher level it’s easier to identify in City because you have less layers.”

“ I can’t even tell you who the District Manager for learning disability is for County”

The second of these comments was especially telling, since there was no such thing as a District Manager for learning disability in any part of the County or District structures, a fact of which the consultant was obviously ignorant.

As well as fragmenting responsibility for learning disabilities at the highest level this structure also meant that, above the level of CLDT Team Manger, there was only one other individual within the entire County structure, the Commissioning Officer (Learning Disability), who was solely concerned with this client group. All other management levels which included a learning disability remit also involved responsibility for other client groups in the community care spectrum. One insider justified the system as follows:

“The model we have is that Districts manage operational services. So we don’t have a specialist learning disability block of services. We have learning disability, mental health, drugs and alcohol, HIV services being managed as units and teams but then under one Service Manager who oversees them. And that had advantages and disadvantages. The disadvantage is you don’t have the same specialist knowledge of learning disability. The advantage is you can tap into a range of funds and initiatives that are more widely available.”

But this, albeit guarded, defence of the County structure was not echoed by colleagues elsewhere in the system:

“I mean, it’s very clear that older people and children are the higher priority groups in social services. So learning disabilities within social services only tends to get a... to be a very high priority at a lower tier in the organisation. And I think that then affects the ability to strategically manage and develop learning disability services, because you’ve got less

powerful people trying to defend and maintain and extend learning disability services.”

One CLDT Team Manager who worked within the County structure described the situation as follows:

“You do feel quite divorced from the people who, at the end of the day, really hold the power and the purse strings. You know, the way we have sort of set about having almost mini social services agencies in each District, having a District structure, has in terms of learning disability services, I think a lot of people would agree or... or would submit that it has been potentially quite divisive and sort of...you know, quite a diminution maybe.”

And another expressed ambivalence about the admittedly low profile of learning disability within the County:

“I suppose, at one level, it doesn't bother me unduly that I'm not tangled up in what's going on at the higher echelons... at one level. I mean, I do find it frustrating at another level because, you know, what's that saying about communication and... and feeling a valued part of an organisation.”

There was sympathy amongst health service staff concerning the difficulties that the new social service departments were experiencing, and from some quarters came an acknowledgement that this in some ways mirrored the problems experienced by health services during previous NHS restructuring. It was clear that every major restructuring of either health or social services had hindered the development and maintenance of collaborative working practices:

“I think the changes forced both organisations to look internally into their own organisation for a while, which detracted from the energy that could be put into joint working. And there was a lot, I think, of energy that Trusts themselves had to put into becoming viable organisations. And some of that energy was not around partnership working, it was around developing a sustainable organisation of selves. And some of that actually even mediated against partnership working.”

At the same time, however, comments from health service workers about their experiences of working with each of the new social service departments indicated that service structures did have an impact upon collaboration. In particular, the fact that the City had a single individual in charge of learning disability services appeared to be viewed with widespread approval by health service managers:

"The City have got a greater coherence of delivery of services, I think."

"It seems as though it may be a bit easier in the City, but that's only a personal perception er... because it... it may be easier to get access to one person that you know is L.D. supremo in the City, whereas in the County I think it's probably less defined."

Social workers in the City also agreed that their clear structure helped to encourage joint working:

"We've got... you know, one Service Manager with a specific brief for learning disability erm... managing residential, day care and learning disability teams and going to commissioning groups and being the... the contact between the department and health and other agencies, housing... education."

This contrasted strongly with comments about County social services. An earlier quote showed how a consultant was unaware that the County did not have a District Manager for learning disabilities. Other health workers commented on how the complexity of social services had impaired joint working by making it more difficult to maintain person-to-person contact between the two organisations:

"I'm conscious, from my point of view, that following LGR I now have erm... one, two, three, four, five different managers to liase with at social services, and that's a struggle. And then the commissioners on top of that as well, so there's actually seven different people and that's really hard. And all of the County ones all keep changing, so it's even harder. I couldn't tell you, for example, who is District ***** manager at the

moment. This time last year I could have, and had a dialogue and worked hard on establishing those relationships."

It may not, of course, actually be true that turnover of personnel was any more rapid in the County than in the City, but having to liaise with many managers rather than just one had created the impression that this was so. The danger is also that this may lead in turn to less effort being put into forging future relationships with County staff, based on the false assumption that such efforts will be wasted.

Even within the County itself some managers acknowledged that their structure caused certain problems and compared unfavourably with other possible set-ups:

"In social services it's very difficult to actually meet together across districts and centrally and to agree the way you're all working. Whereas in health you feel people are all based together, they have a chance to work out a common agenda and to all work to the... to the same approach."

And this lack of clear leadership or direction was also felt lower down the hierarchy:

"One of the things that I suppose I do find a little bit frustrating at the moment, being relatively new... for a while I was thinking it was because I was new that I didn't know what was happening, yeah? Then I realised it was because the strategy was only sort of really being developed as we spoke."

But recognising the existence of such difficulties in theoretical terms did not eradicate their impact, and at times made it harder to distinguish between the twin influences of service structure on the one hand and individual personalities on the other:

"There's a lot of personal collaboration and... and er... good will around to... to achieve some sort of er... effective answers. What I'm not clear about is whether the fact that some things don't come through is because of individuals not being confident enough to see them through,

or whether there are sort of organisational pressures that prevent them from seeing those things through."

This confusion between structure and personality will be examined more fully in a later section.

The final sting in the tail so far as the structure of both City and County social services was concerned, was that they, like their colleagues in the health service, also had a non-management power base which could strongly influence services: local councillors. Because councillors are political creatures, rather than highly trained professional clinicians as is the case with medics, the result of their involvement was felt rather differently. One social service worker explained the situation as follows:

"I think the democratic process within local authorities puts a different emphasis on how you work. Although there are... you know, trust boards and... and that whole process to go through as well, which might be seen as equivalent... I don't think it's quite the same though."

Another was more forthright, stating baldly that:

"It can be frustrating working with politicians who don't really know what you do."

While a lone voice spoke out in defence of local democracy:

"I think it's helpful having, at the end of the day, members' input. I mean, we might not like it that social services committee members... you know, elected representatives, have voted through various amounts of cuts and things like that but... I mean, I think that on a political level it's still advantageous that there is that connectedness. And again... you know, that often goes in cycles anyway and it would only probably take a couple of councillors who have got learning disabled relatives or whatever to actually sort of pump up the political profile as well."

Other social work colleagues felt that the role of councillors, and their limitations, needed to be given serious consideration.

"I think that sort of debate needs to go on within staff groups, it needs to go on within the elected members who.. you know, at one point we're doing an assessment and trusting people to do an assessment.. if that carer rings up the local councillor or MP pressure comes on from above `Let's scrap it all and give them this anyway`."

In some ways councillors and consultants had a remarkably similar effect upon their respective organisations, each constituting a higher authority with great power but little discernible accountability to the formal management structure.

Community learning disability teams - area A

It is within CLDTs that the success or failure of co-operation between health and social services is felt most keenly, since this is the operational level at which individuals from different organisations come together in the delivery of services. The structure of the six CLDTs in area A at first appeared straightforward, with little in the way of managerial hierarchy since all team members are directly answerable to their team manager. However this simple structure was complicated by issues of 'line management' versus 'clinical supervision' and 'core' versus 'extended' team members:

"And from the middle 80s the Community Learning Disability Teams had both core and extended members, some of whom were employed by social services and some of whom were employed by the health authority."

All core members of the CLDTs in area A were based in social services' buildings and, with the exception of community nurses, all core members were social services' employees. This gave rise to the overall impression that CLDTs were largely social service entities rather than being truly multidisciplinary:

"The teams work well together but it doesn't go beyond that. And we still have hiccups over 'we are social services': 'we are health'. Erm... and we still make barriers over just basic things that ought to have been sorted out. And so an example recently was over accommodation and erm... the standards of accommodation, because all our CLDTs are held in social services' accommodation."

And this was compounded by the fact that there was only one community nurse based in each of the CLDTs:

"I think this just being one community nurse within a predominantly social services team can make it quite difficult on your own to be very focused and to keep within your role. I think you do tend to get absorbed into the social role side of things."

Such social service dominance had the potential to engender feelings of insecurity, as highlighted by a health worker who had previously worked in mental health services:

"I think the major difference in... in comparing the Directorates is that health was the lead in my previous one and so potentially, as a health worker, I never felt threatened. This is in hindsight... I was never conscious of it at the time, but with hindsight. Whereas... whilst it's not official that social services are the lead in this service, I think that does have a bearing. And the majority of workers in the CLDTs are, of course, social services' and not health."

Non-core members of the CLDTs were all health employees:

"The extended team is psychologists, psychiatrists, speech therapists, physiotherapists, erm... and they come into the team as and when they are required to... to work on cases, but also attend extended community erm... an extended team meeting that happens, I think, monthly or six-weekly."

Most of these extended CLDT members were based on the long-stay hospital site, the exception to this being speech therapists:

"Speech therapists work for another trust, so are based at one of the team bases but all together."

And this geographical complexity was not viewed positively by team managers:

"We've got a core learning disability team here with extended team members out there, at the hospital very often, erm... and I'd like to see us all on the same base and all located together, without a doubt. Not on a hospital site, I'd want to see that knocked down."

In theory the CLDT Team Manager, who in each case was a senior social worker, had full managerial responsibility for all members of their core team. In practice, however, community nurses and other health workers received additional clinical supervision from elsewhere:

"What happens at the moment, although I'm the team manger, I'm not the line manager for every member of the team. The community nurses are line managed by the nursing structure, the OTs through the OT structure, erm... the voluntary sector worker, obviously, through her own organisation. Although... I mean, I meet with everybody because obviously... you know, I need to know what people are doing in terms of the cases that they're working on."

To add to the uncertainty of the situation the team manager was also, theoretically, the gateway by which all referrals to the team were received prior to their then being allocating amongst team members, according to the nature of the referral and the existing caseload of individual workers. Community nurses, however, also routinely accepted the referrals which came to them directly from consultants, thus bypassing the formal structures. Nurses did not appear to regard this practice as problematic:

"They would be allocated by the team manger, that's how we receive our referrals. I often get direct referrals from the consultants, they'll come straight to me, but then I'll always inform the team manger so that they're aware of.. of who's open to us."

But team managers themselves found that this sidestepping of the official system impeded their ability to manage their team's manpower effectively:

"I don't see all the referrals that come to this team. Nurse referrals go... often go straight to nurses, they don't usually come through me.

Sometimes there'll be internal referrals, from a social worker across to a nurse. If a medic refers to a nurse, I don't often see that referral."

"The first thing that I will hear of it is a community nurse coming to see me and saying 'I've been referred this case and it needs a social worker, it doesn't need me'."

If the issue of client referral routes did not make the situation complicated enough there was the added complication that health and social services did not share the same criteria for accessing services:

"The Community Learning Disability Team is made up of health and social services professionals, but we have different criteria for accessibility of service, which I think is a real key thing when you're sort of having a seamless service. So someone could have a community nurse, could have an occupational therapist involved and they may even have a speech and language therapist involved, but unless they meet the criteria as having a moderate to severe learning disability they wouldn't have a social worker from this team involved. So clearly you end up with situations where a social worker may not be involved for someone who has social care needs, and social workers from other teams may have to do that aspect of the work."

Other non-core team members, such as psychologists, might take referrals from a variety of sources:

"Self-referral is possible if a client is capable of doing so, erm... families and advocates can contact us, as well as more conventional sources such as CLDT workers, GPs, day services. Basically we try and ensure that as many people as possible are aware of our existence and how to get access to us."

In effect, the benefits which could have been derived from the multidisciplinary operation of CLDTs was often mitigated by lack of a clear, unified system of management:

"I also suspect that the current managerial structure that we have doesn't help. Erm... I think that the health workers in the teams currently have two bosses, for want of a better expression, or two immediate bosses, two immediate line managers, and that confuses issues. And I think that also enables people to... to split and then create dynamic differences and difficulties."

Team management itself had the potential to create resentment amongst health staff because only social workers are eligible to become team managers. Only one current team manager expressed concern that this situation needed to be rectified:

"All the six teams are led by social services and actually I wouldn't... I would not be critical of moves to erm... having another team or select a post or two where there's a nurse manager running it. Because I think that then brings us together at operational managers' meetings and I think that can be... generally beneficial."

This may explain why community nurses looked elsewhere for guidance, as they have no hope of advancement other than by leaving the CLDTs and moving over to hospital-based managerial positions.

The lack of seamlessness within CLDTs not only created problems for CLDT members, but also had a direct knock-on effect for clients. One concrete example of the lack of co-operation at this level was that while social workers and community nurses from the same team may often have the same clients on their caseload they were not able to cross reference case notes because health records were maintained and stored separately from those of social services. Whilst managers from both health and social services expressed a desire for this problem to be eradicated they also reported difficulties in initiating such a change:

"At my level and the level above we assume that that would be fine, that we're all working to the same level of accountability and confidentiality, and that people would accept that. And what we got was er... the nurses, particularly the nurses, saying 'We know health records are confidential and we shouldn't be sharing them with anyone else'."

So whilst one team manager puts:

"Probably shared filing, shared records"

at the top of his list of possible service improvements, there were still audible murmurs of dissent from team members:

"Talk's already going on about using joint files. Which is okay if you're in a ground floor building... if you're all in one room, but if you're all on different floors... you know, and you're having joint files, who keeps the notes and who's going to do all the running up and down stairs?"

Clearly filing of records is not a make-or-break activity in determining the state of inter-agency relations, but problems in achieving such a simple and obvious improvement to joint working practice was indicative of the somewhat strained relations between health and social services in area A.

Lead agency status - area A

The organisational structures both within and between health and social services operating in area A were complex. This complexity arose not simply from the combined vagaries of the three different organisational structures but also because of the lack of any clear leadership that could impose an area-wide strategy. It was the overlapping boundaries between health and social services in area A which created this problem and made the concept of a lead agency (as envisaged in the community care legislation) a practical impossibility. If the lead agency role for learning disability (or any other client group) was given to social services then the health service in area A would be placed in the impossible position of being answerable to two lead agencies, because they

work in conjunction with both City and County social services departments. If, on the other hand, health services were to take on the mantle of lead agency status then County social services would be put in the same position of having to answer to two lead agencies, since its boundaries embrace those of two health trusts.

Interestingly, of all those interviewed in area A only one person, a senior social services manager, made direct reference to this conundrum when asked about the lead agency issue:

"I'm not sure how it will work now because, I mean, one Health Authority, two social services departments. And of course the County have got two Health Authorities to relate to. So I think that will be the most complicated thing to manage and I don't know how you manage it. Because do you have two lead agencies? Or do you say one of the social services departments will lead for everyone?"

Despite this, most interviewees had an opinion about which organisation was, or should be, the lead agency for learning disability. While the majority believed that social services were or should be the lead agency, two senior health workers argued that, in fact, health had become lead agency by default:

"I think we in the health service get extremely mixed messages about whether we are a specialist resource or whether we... we're the resource of last resort, which is I guess lead agency... where, if everybody else can't sort it out, you have to."

"I think that government has made indications that social services would be lead agency, but that in fact isn't really being played out here because as a health trust we take huge responsibility for large numbers of people who we could argue aren't health's responsibility but, because social services aren't taking the lead role, they continue to be provided with a service here. So there isn't any... effectively that actually has not come into practice. And, since the Joint Commissioning Officer has been

based with the health authority, I think that the health authority has been taking more of the lead."

And one community nurse argued that, in effect, lead agency status had been handed over to the independent sector service providers.

"I'm not sure that social services are the lead agency. I mean, I think at the moment what I'm seeing is that the private and voluntary sector are fast moving into being, certainly in residential care, becoming the lead agencies."

More commonly held, at least among senior staff, was the belief that the lead agency issue had yet to be resolved:

"The lead agency status has been around for quite a time and in *****, in a way, I don't think we have particularly given that a high priority. I think we've tried to look more at working together."

"We've got it coming, it's got to be one of the next things on the agenda. But certainly with us... I mean, that would be the health authority's agenda, that it's social services leads on learning disability and er... that health lead on mental health. But it's certainly never been anything... I mean, we've talked about it, going 'Yeah, yeah, yeah', but we haven't actually changed anything yet. But, yes, it is certainly on the agenda."

But frontline workers were more likely to express the view that social services were already de facto lead agency:

"And who takes over who? There's those sort of take-over issues really... you know, who is the lead agency? It looks like it's social services, in learning disability, at the moment."

This tacit recognition of social services as lead agency was justified by health workers on the basis of the practical realities of the situation:

"I think it makes sense having the social services as the lead agency erm... simply because looking at the profile of needs... I mean, from personal experience of needs of all the people that I have had contact with, that there certainly is a lot of needs that requires the intervention of

the social services. So I think it's... it is a good idea that the social services take the lead."

"I don't think health could have been a lead agency for a specific group. I think it would've been far too complicated because we're not terribly integrated into erm... into... you know, local councils and all of those things. I think it wouldn't've made a great deal of sense."

And was defended by social workers as sending an important message about the ideological direction that services should be taking:

"In terms of philosophy... you know, we're actually looking at people having a community presence and being more integrated into mainstream communities. So I think ultimately, yes, I would say that erm... you know, it would seem most appropriate that it would be social services as lead agency."

"I think there's a message there you see, and I think the message is erm... moving away from hospital-based services, moving away... trying to counterbalance the medically-driven service. And I think it's crucial... and I'm very pleased. It's a shame it isn't that within mental health, but I suppose there was a deal done."

Looking to the future, there did appear to be some hope that this issue could be settled without giving rise to undue conflict. The most frequently voiced opinions about lead agency status was, firstly, that it was not of vital importance:

"Why do we need a lead agency is my first question, I would have thought. Why does one agency need to lead the other?"

And, secondly, that what was really wanted was truly joint services rather than the continuation of the current model of separate health and social services agencies for learning disability:

"I think my... yes, my fantasy, if that is the right word, is that... is that it would work better if it was one agency, erm.... with one very clear structure. And my hope is that... you know, that if that doesn't happen then at least funding streams will be merged."

"Erm... (sighs) this is where I get frustrated. I just think they all ought to be put together. I don't... I don't see the point of continually battling it out."

"I think you're probably going to end up with erm... some... I can't see any way other than having a team, a small team or a small group of people who work across the agencies. I think it has to be something like that."

"While ever there are two distinct pots of money erm... that people then, by their very nature, will protect... that there will always be the potential for conflict. If you've got one local agency charged with ensuring community care takes place that then immediately removes that."

Although some interviewees did succeed in finding a positive slant on the existing status quo:

"I think I'd prefer it if there was just one agency dealing with the lot, but I suppose the tension could be perceived as quite creative. Because you've got different models coming together and neither dominates, and it's in the playing with the tension you probably get the best fit, the best value for money, the best clinical fit. But that is so dependent on relationships and pragmatism... erm, I don't suppose you could advocate that as a model, really."

for every such optimist there was a countervailing argument put that current systems were failing:

"You've got the situation where health are currently commissioning places in the community in order to move people out of long-stay beds at *****, but that's bringing them into direct competition with perhaps social services who may not have the dowry or the pot of money necessary to purchase things for people who may be living at home. So there becomes a competition for places, rather than again it being one agency who's charged with having a strategic overview and implementing that plan."

Pooled budgets and joint management – area A

Given the myriad structural factors which mitigated against effective joint working between health and social services in area A it was not surprising to find scant evidence of moves towards pooled budgets and joint management of services. Nevertheless, many interviewees, particularly those who were CLDT members, voiced strong support for the idea of pooling budgets for learning disability services:

"I think if funding streams were merged ... I think that would make a huge difference in the way we practice and the way that we provide services."

"If you had a pooled budget ... I mean, that would make a lot of sense. And certainly I think there's a view that maybe we should be moving that way."

"Pooled budgets, again ... I think, would make life a lot easier."

"I mean, for my money, I just want all the money in a social pot. It's coming from the same source, it's funding the same outcome, so why not recognise it as together?"

The view from management was rather more circumspect. One senior health manager boldly declared that:

"... we've got that now, pooled budgets. I mean ... basically what we've got at the moment is we can do anything."

But other managers, from both health and social services, were quick to point out that pooled budgets could present as many problems as the existing status quo:

"I personally don't think there are any easy options around pooling budgets ... joint organisations, although I do worry about health being more exempt from budget cuts than social services and whether there could be any way around saying to Local Authorities 'You can never cut social services' budget', for instance."

Unless the move was accompanied by further radical advances in collaboration:

"It sounds great, doesn't it? In practice ... but actually then it's 'We've got a pooled budget, but which proportion of this pooled budget is mine and which proportion is yours?' And the only way to do it, I think is actually have ... just somebody managing it who actually does genuinely work across the two, is actually jointly employed and jointly responsible."

The last quote indicated a willingness for co-operation to progress well beyond the present situation, but this seemed a long way off. There was no evidence in area A of any existing or planned joint management of services. There were, however, several mentions made of a system of joint commissioning of services between health and social services. This joint commissioning process had developed as a means of reducing the inter-organisational friction over who should fund which services by formalising the decision-making process.

Two slightly different stories were told about how this system had begun:

"The whole thing blew up in a very dramatic way when the money began to run out from the social services side and they started overspending. What we have done since is look at implementing a joint commissioning process."

Or, alternatively:

"The main area of difficulty is deciding what percentage of funding was to come from health and what was to come from social services. And that's why things like the difficult decisions panel and the joint commissioning group has.. has sprung up, because there were difficulties in those areas."

Despite these somewhat shaky beginnings, the joint commissioning group had begun to move beyond its initial remit of simply being an arena in which financial disputes could quickly be settled. One group member described the progress in the following terms:

"The joint commissioning group is multi-agency and so, as a result of that, a significant group of multi-agency personnel have been working together to develop a strategy for the next five years. And that has led, I think, to an enhancement in relations because people have had to talk to one another and be involved in that process."

Which, at least, gave some indication that health and social services in area A might eventually be able to overcome the immense structural obstacles in their path and achieve a desirable level of co-operation.

Lines of communication – area A

As might be expected, given the inter- and intra-organisational structural anomalies and complexities which bedevilled learning disability services in area A, communication within and between health and social services was often poor. Interviewees from County social services were particularly aware of their organisation's potential problems in this area:

"I think wherever you have a diverse structure of management communication becomes essential."

And how this was a common difficulty within some parts of the public sector:

"I mean, mental health enquiries all refer to poor communication."

A health manager recalled the additional stresses placed on inter-organisational communication by the reconfiguration of local social services:

"I think effectively it's the same agreements have been maintained, although the difficulty of actually implementing those agreements with people has become more difficult with the changes.. finding the right person to talk to."

But, in general, interviewees from area A had very little to say on this subject. This may have been due to insufficiently direct questioning, but could also be interpreted as indicating a reluctance to dwell upon an area of work practice

which was falling well below what was required. There was some evidence, as in the description earlier of the joint commissioning group, that this state of affairs was slowly beginning to change, but there remained huge scope for improvement.

Chapter 5.2.ii

Organisational structure of services

Health services - area B

Health services in area B have a simple structure (see figure 4, appendix II), and one in which both operational management and strategic functions are represented in the second tier of the organisation, answerable to the Director. Within the wider structure of the local trust and health authority, the learning disability directorate is a largely autonomous unit, with the power to broker contracts with service providers and the freedom to determine how to spend their allotted budget. The Director of Learning Disability Services described the organisation as follows:

"We have flat structures but we have... I think we're very well managed, but not hierarchical. I think we have clear roles for managers and clear responsibilities and clear lines of accountability. Erm.. but we don't emulate any professional model. We don't, for example, emulate medical or nursing hierarchies... we've done away with them and we've got a general management structure in place which is relatively flat, there's only three or four tiers."

Despite this there remains an impression from both health and social service staff that the health service is organised along more hierarchical lines than social services. A social worker stated simply that:

"I think it's much more hierarchical in the health service."

And whilst a health manager agreed that they felt to be the case, they also suggested a plausible historical explanation for this:

"My gut feeling is that maybe they have less hierarchy than us, but that's only a gut feeling. I don't know why I think that. And... I mean, we

haven't even got that much hierarchy any more. We used to have sort of layers and layers of people and I don't think we have that any more."

All of the senior health managers are based together in a building close to the site of what was once the long-stay learning disability hospital, but other parts of the service are scattered widely:

"We have about eighty-five different locations to manage within the city... you know, whether they're little houses, big nursing homes, big day centres, hospitals ... whatever it is there's a lot of locations."

This does not appear to cause any particular problems, but had been a significant factor in determining the management style of the service:

"We've adopted a pro-active style because it... or a pre-emptive style, which ever way you look at it, erm... in some ways we're trying to avoid criticism or arm ourselves for the criticism in some way. But it... it's one of the few ways that you can manage a highly dispersed service."

Learning disability consultants in area B have a purely clinical role and are not involved in either the strategic or operational management, although it was not altogether clear whether this was by chance or by choice:

"We're very badly off for consultants in learning disability. We just seem to get people who are retired, retiring or really past retirement."

Very few interviewees made any reference to the issue of consultant power. One of the few who did was a CLDT social worker, whose comments illustrate both the attempts of a consultant to wield power, and the resistance this met:

"I know that there is a bit of a pull at the moment from a new consultant we've got in learning disabilities who is sort of wanting a nurse, one of our nurses, with him all the time to be like a minder... you know, to assist him. So there is... but he's not been here long"

"I think the one we've had for a while has... sort of treats us as members of the team, whereas the new man... he has still got quite a bit to learn really."

One health worker made reference to other, non-medic, profession-based power groupings within the health service:

"There are little power cultures around as well like psychology and clinicians' team, so that's... you know, just to er... rock the boat a bit."

But this was a lone voice and the overall impression remained that health services are organised along clear lines of responsibility and that the management worked in a unified fashion.

The only significant area where negative comments were made about health management was in relation to their input, or rather lack of input, into community nursing. Both nurses and social workers in the Community Learning Disability Teams commented to the effect that they felt distanced from the health service management structures. A nurse described the situation bluntly:

"There's a social services manager here who gives me my caseload, and I also have a nurse manager who's of an equal rating to him who I never see."

When asked why this was, the reply came back:

"Erm... I'm not sure really (laughs). Erm... well, he's not very sure who I am, so I suppose that helps."

And the same person then went on to say:

"I think that the support we receive from social services is great and is more than we receive from health, which I think is strange. I think it's strange that our health manager doesn't have more input into what we do."

The views of social work colleagues in the Community Learning Disability Team were equally forthright:

"The health service management, I understand, does not know what this team does. I mean, ***** manages both nurses and social workers, but they have their own system as well. I don't know...I just get the impression that health management is out of touch with what's going on,

really, for... as far as the lives of... well, the service offered to people with learning disabilities and the work that the nurses do."

Social services - area B

Like health, social services in area B have a relatively straightforward structure (see figure 5, appendix II). Learning disabilities are represented at the third tier of social service structure, answerable to the Assistant Director: Disabilities and Community Health. There are five Assistant Directors in all, four of whose roles are split along the operational lines dictated by client groups and a fifth who takes responsibility for resources and quality assurance across all of these sectors. At the third tier of management, where learning disabilities first get a voice of their own, there are two learning disability service managers. One is responsible for residential services and the other is responsible for day services and care management.

This division of learning disabilities management roles did not appear to cause undue difficulties, although at least one person lower down the hierarchy did comment upon the split:

"I think from a social services point of view there are times when it would be an advantage, or it would be useful to have, a single social services manager... because we kind of have two who share the job."

Despite this, however, others compared the management structures of social services favourably with those of health:

"It seems to me that there is more management tiers within the Trust provision than there is within the social services provision. We're very flat. There's a third tier officer and then you're straight to unit level. Within the Trust there are a number of additional tiers which means they've got more management time, which is great, but also means that, I think... you know, they're operationally erm... their senior managers aren't quite as aware what's happening on the ground. So... I mean, as a service manager within learning disabilities, the disadvantage is that you get drawn into a lot of operational issues when you're trying to think strategically, but the advantage is you actually know a bit more about

what the service is really like when you're involved in planning new services."

The only complication within the social services structure was that found in all local authority services: the relationship between officers and councillors. Some commentators from the health service saw councillors as adding to the bureaucracy of social services without necessarily having much expertise:

"I think they've got a lot more hierarchy because they've got a second set of masters, haven't they, which is the local Council. And in a way that's a hierarchy because they ultimately have to rubber stamp things. So I think that's a disadvantage, you know. Again I'd have to say that it's very dependent on the group of councillors that you might deal with. Certainly some will be very good and know what they're at, but I'm sure that... you know, the arguments and the way that things are presented and the way that Councils approach issues will be very... may be biased against social services in some cases."

And one social worker alluded to the occasional politicisation of decision-making on the frontline:

"There's a big population of vulnerable adults which is quite a hot potato. I mean, we try and gate keep so that we don't take vulnerable adults in... people without a significant learning disability, but in reality there's no other service in ***** that takes them. So we tend to deal with the vulnerable adults who hit the headlines, or where we get told to do something by management because it's going to become embarrassing or political."

For the most part, however, those who worked for social services were more likely to emphasise the positive aspects of relations with councillors:

"We're a consultative organisation, we're accountable to members. Members, political members, are very actively involved in the field and have a good understanding of learning disability services. And therefore

we do get involved with politicians quite a lot about how services are changing, or complaints about services."

And how this in turn positively influences relations between social services and the wider community, in a manner which health was unable to replicate:

"Health services aren't as publicly accountable as us for a number of reasons. I mean, firstly they don't have the political accountability, secondly their services users don't have the same level of carer involvement, but thirdly they're not as used to operating in the community as we are."

Community learning disability teams - area B

The structures of the Community Learning Disability Team in area B, like those of their two parent organisations, are very straightforward. The team consists solely of social workers and community learning disability nurses, with all other therapists such as psychologists, physiotherapists, speech therapists, occupational therapists, etc operating as separate specialist teams to be called upon as and when required for individual clients. The team is split geographically across three sites, but this did not reflect any corresponding geographical responsibility for clients. Interview access was only gained to one of the three sites, which was also the base for the CLDT manager and one of social services' two learning disability service managers.

The CLDT appeared to function well as a multidisciplinary unit, but it was acknowledged by those interviewed that staff based in other, non-management, locations:

"Would find it more difficult to get hold of people and maybe even just to recognise who people were and what their role was."

As well as the geographical division the team was also split along operational lines:

"The Community Learning Disability Team is split into two, both of which have assessment functions but one deals with the duty aspect, so... referrals and duties to school leavers and the other team deals with the ongoing assessment of the whole population of people with learning disabilities."

In addition, two senior staff, one social worker and one nurse, had recently been seconded to set up a new system through which the outcome of individual care plans could be monitored. They were referred to as the "C.O.R.E. team", and although nobody was able to recall precisely what this acronym stood for their remit was clear, to:

"... provide reports and monitor services.. the delivery of care, in all services irrespective of who is the provider."

The teams are composed of roughly equal numbers of social workers and community learning disability nurses, all of whom are supported by a single team manager:

"All the social workers and all the nurses... there's about thirty people, and only one manager for all those people. The nurses have clinical supervision managers who they go to for clinical supervision but as far as workload management and managing the team as a whole, managing the workload of the team, we've had one person."

And it was the relative dearth of management input, rather than any concern over the quality or professional background of the existing manager, which emerged as one of the few areas of complaint:

"It's not been feasible for one manager to have a.. a complete grip of what everybody is doing or the direction in which things are going. So there's been very little thinking time, I think, for CLDT. And.. and we've done quite a lot of that together, as social workers and community nurses, mostly without major fallouts.. you know, we haven't scrapped much. But we.. I think we've certainly lacked direction and we've

lacked.. we've lacked if you like a strategic thinker within the team.

We've all been operational-level thinkers."

Although even this perceived lack of strategic direction was now being tackled by the C.O.R.E team, one of whom described the situation currently as:

"We've got lots and lots of providers, very little networking, very little sharing of information. Information systems that we're looking at that have been set up, like the register, are frankly not very good.. they're not very accurate, they're not maintained well, the information's always on it's wrong. But there is no central point at which all information is brought together and looked at collectively and turned into useful information and.. and things drawn out that can inform plans. So that's really much of what our remit is. It's to monitor the care plans to see.. let's see how we're delivering care as prescribed by the care plan which involves the user, erm.. and what are we learning about the profile of our services: the needs that are outstanding, where the service shortfall are, where the gaps are and what's the effect of a changing population."

As the team manager explained, the current harmony within the CLDT had not always existed:

"Originally there were quite a bit of problems because we had a nurse manager and a social work manager, and people felt it was very hard to get decisions made. And people for quite a while found it hard to accept the concept of being managed by somebody who wasn't from their own profession. As time went by people moved on from that position and the nurses, bravely I think, agreed to have me as their... managing them. And I think that was a big step for them. And I think it was also a big step for both organisations in their thinking about having a joint service and one part taking responsibility over other people's staff."

Other long-serving team members were also able to recall that the early days of the CLDT had not all been plain sailing:

"Going back to when we first started, which was in 1987 we first started working together, and it was quite difficult then with the...

predominantly it was male, experienced male nurses getting used to working with female social workers, and there was quite a bit of friction there."

But there was little evidence of any friction remaining between social workers and nurses:

"I think that on the whole we get on as well as large teams do anywhere really."

"I don't think, as a team, that we have.. you know, on a workers level I don't think that we have any problems at all."

And the impression that the CLDT had projected of itself to other parts of the local learning disability services was clearly one of harmonious collaboration.

A senior health manager said:

"I don't go to all the CLDT meetings and I don't know all of their business but I'm not aware of any great problems with them working with social service colleagues. In fact what I pick up is the opposite, they seem to work fine together."

Both groups of professionals within the CLDT spoke highly of colleagues from other backgrounds and emphasised the positive aspects of working in a multidisciplinary environment. A social worker expressed the opinion that:

"I've found that working with a community nurse has actually produced good work, a good standard of work. So as a worker I've had good experiences of working collaboratively with the health service."

And a nurse in similar vein echoed:

"I don't think, as a team, that we have... you know, on a workers' level I don't think we have any problems at all. I think it works really well most of the time, because if we have worries about something we'll ask one of the social workers for input or help or whatever... and it works both ways."

The fact that nurses were being line managed by a social worker did not appear to be a cause of any undue concern:

"I think that the support that we get from social services is great."
And a nurse explained how, in theory at least, the nurses working in the CLDT continued to receive professional support and guidance from nurse managers within the Trust:

"There's a social services manager here who gives me my caseload and I also have a nurse manager who's of an equal rating to him whom I never see.

Interviewer: Why not?

Erm.. ..erm.. I'm not sure really (laughs). Erm... well, he's not very sure who I am, so I suppose that helps. I think he's erm.. (sighs).. I guess he feels that there's not anything that he needs to directly see me for."

This lack of support from nursing managers for those nurses working in the CLDT was a source of some dissatisfaction:

"It's annoying and it makes you feel undervalued, it's like we don't count. It's almost like we've been left to get on with it, with hardly any input from health at all really."

Social workers were aware of, and sympathetic to, the lack of professional support being given to their nursing colleagues. They reported having heard:

"Comments about the nursing management... the nurses feeling that their manager hadn't really got a clue as to what job they did... you know, assuming that they just do nursing tasks maybe."

This fortunately did not appear to have diminished the ability of the team to work together effectively. One social worker explained the team spirit as follows:

"The team has been self-motivating, self-generating and under those circumstances I think the team has done very well. You know... we've managed to hang together as a group and we've managed to actually turn out a lot of reasonably good work."

And another commented upon the way in which nurses, perhaps because of their lack of effective professional supervision structures, had developed their own support systems:

"I think what the nurses have, which the social workers don't have, is... well, we believe that they have... they seem more as a group to get together and support one another a lot more. Social workers in this team have never really met together as a professional team, as such, to discuss social work-y issues."

Although the CLDT was generally an excellent example of co-operation between health and social services, there were still operational issues outstanding. The chief area of discontent concerned issues involved in the allocation and completion of community care assessments. All referrals for the CLDT come first to the team manager, who then decides which team member should be assigned to deal with it. The team manager explained that allocation decisions are taken by:

"Looking at the needs of the referral, but taking into account how busy people are and how urgent it is. So there might be some... some cases will come in and you can say `We could do with nursing skills on this one and we could do with social work skills on that one`. But the majority of referrals you couldn't identify which would be the best person to deal with the assessment because most requests are asking for quite simple things and until we actually go and visit and find out more details we don't have sufficient information to make the decision... whether it should be a nurse or a social worker."

But the clear view of both nurses and social workers was that there was only one factor of any significance. A nurse stated that:

"It just depends who's got space."

Interviewer: As simple as that?

"Mmmm. I mean, unless it's a really... if the person has a lot of health needs then it would maybe come to a nurse, but not necessarily. If none of the nurses have got space at the time then it would go to one of the

social workers. And they would then maybe ask for input from us, but it would be their assessment."

And a social worker echoed:

"The space... who'd have the space, really. But it's a shame really, there's not much joint working that goes on. We tend... you know, if I've got a case that is someone with a lot of health needs I'd ask for a nurse to give me advice or to come and do a little bit on the assessment, but we wouldn't sort of joint assess. And I think some opportunities are missed there, really. Because there are things that a nurse would think of that would never enter my head and... you know, if it doesn't enter your head you don't ask a nurse about it, do you? There is something lost, I think, because of the way work gets allocated."

This random element of this allocation process for referrals was felt to have knock-on effects within the team, in terms of both the outcome of assessments and the definition of professional roles. Social workers explained the effect on individual assessments as:

"Both disciplines do assessments, but I would say the way we approach them are different from the way that nurses approach them."

"Sometimes you would think it an arbitrary decision about who got... whether you actually got a social worker or a community nurse. But I do think that it actually made a difference in so much as the social workers would concentrate more heavily on social issues and vice versa with the nurses on health."

And a nurse also agreed:

"I think you could probably tell from looking at an assessment whether a social worker had written it or whether a nurse had written it, because we tend to focus on different things. And certainly the nurses are more health-oriented, making sure someone's health needs are being met... like they're going to the dentist or they're going to the opticians or they're having enough exercise or whatever, compared to social work assessments where it tends to be much more social... you know, is the

person getting enough social stimulation or leisure activities and things like that."

Interestingly, both nurses and social workers stated that they enjoyed doing joint assessments:

"I think there is a good working relationship, but I'd like to see more joint working between members of the team."

Because:

"I think it's a lot more successful and you feel... you know, quite supported if you work that way. You don't feel as individually responsible and frustrated when things aren't working. And I think it improves the services as well."

However, despite this:

"Joint assessments are not common within ***** CLDT, not true joint assessments where you both do an assessment together."

One reason cited for the relative dearth of joint assessments was:

"I think it's just lack of time, really. Erm... yeah, it's lack of time."

But other, more candid, views were also expressed:

"I quite like having different disciplines and perspectives all getting together and giving their opinion of somebody, but it's hard to get that because it's hard work... isn't it? (laughs) It's a lot easier to get in there and do an assessment and think you've covered everything, but often you haven't."

However, any issues arising over the completion of community care assessments were very clearly matters of an operational nature, due largely to constraints of time and money, and did not cause conflict along professional lines within the team. When asked whether, in practice, this meant that the roles of nurse and social worker had now become virtually indistinguishable the team manager replied:

"Yes, very possibly. Health are keen to make sure that people's health needs are covered and one of the things we do when we're assessing

people now is have a health surveillance checklist, but social workers will fill those in as well."

And there was also some support for this from view frontline workers:

"I think it works really well most of the time because if we have.. the nurses have worries about something they'll ask one of the social workers for input or help or whatever and it works.. you know, both ways. Erm.. and on the whole.. on a basic level there's not much difference between what we actually do, but we also respect each other differences and different knowledge. And we can share that, I think, most of the time."

However, frontline staff were also able to identify areas which had remained strictly the preserve of one profession or the other, notably that only approved social workers could complete mental health assessments and that only nurses could undertake clinical tasks such as depot injections. It was fully accepted by social workers that professional boundaries had become increasingly blurred within the CLDT:

"I think there's been more of us crossing... and becoming much more aware of health issues, and nurses becoming much more aware of social care issues on a... you know, on a worker basis... on a frontline basis, working with individuals. I think things have got closer and to some extent I think the boundaries have got a bit more blurred between individual workers."

But this merging of roles was welcomed as a positive development:

"Everybody seems fairly happy to... erm... the boundaries aren't that rigid. The longer we've worked together the more the boundaries have become blurred, I'd say. I know we social workers have got better looking at health needs, and nurses have got better at thinking about social circumstances."

The nurses also seemed secure that, despite working within a social services team, they had not lost their health identity, a fact which they based largely on the numerical balance between professions:

"I think it would be different if there were no other nurses in the same office, but there is... there's four or five of us and four or five social workers, so it's fairly even."

But which also had practical value when working face-to face with certain clients:

"There are clients that I have who are very anti social services and very anti social workers, quite accepting of me going in as a nurse but wouldn't have a social worker go in to their house. And so that's quite useful, and in some ways it's useful to be able to separate yourself from social services and say "Well I'm not from social services, I'm from the Health Trust. And I'm not paid by social services, I'm paid by the Trust". And some people find that easier sometimes than having a social worker go into the house."

All in all, the CLDT in area B functioned well, and clearly worked as a team, rather than simply as a group of individuals who happened to be based in the same office. It helped that the same person, who was also the sole route via which the team received referrals, managed all staff. Differences that did remain between nurses and social workers were largely those of professional background, and as such were an asset rather than a cause of conflict. Differences such as those in contractual terms and conditions were accepted stoically. So although a nurse reported that:

"I mean, there are differences... things like the nurses get lease cars and mobile phones and the social workers don't, but I don't think anyone is really bothered about that particularly. I don't think anyone makes it a big issue really."

None of the social workers had felt that this was worth mentioning. The only gripe of this kind which was mentioned was the lack of availability of ongoing professional training for social workers, but this was blamed on wider social service policy and finance rather than being held against nurses:

"There seems to be a greater commitment to training them than there is to us. They often seem to go on interesting courses and various things,

whereas we have to... you know, I think our team's budget, social work budget, is about £300 for the year, which means you could send one person on a decent training course... you know, it's pathetic."

Issues, such as shared record keeping, which had caused some difficulties during the early days of teamwork now appeared to have largely been resolved:

"There was quite a lot of discussion about confidentiality, of why it was that health information had to be so confidential in comparison to any information that we held. And whether if we combined files all the nurses notes would have to go in a confidential section, whereas our case notes weren't in the confidential section; and doctors' letters have to be confidential whereas ordinary correspondence doesn't have, so it's... er... But we're now operating a sort of standard filing system format which I think, really, has finished that."

And, from the perspective of services users, team members certainly believed that they were now offering a seamless service:

"Clients often don't know if they're dealing with a social worker or a nurse, so... you might think that's good or bad! (laughs)"

Lead agency status - area B

As explained above, it is social services in area B who are wholly responsible for the management of Community Learning Disability Teams. This means that social services have become the gateway through which, by means of the care management process, most learning disabled clients access statutory services. As one health manager pointed out, this gives the impression to service users that social services are de facto lead agency for learning disability services:

"The assessments remain the business of the local authority and if people perceive the main provider... for that role alone that's how they'd see the local authority, as main provider... just through the assessment bit, although they don't necessarily provide as a result of that. But they decide the assessment outcome and what sort of provision there should be."

However, despite the public perception, behind the scenes there remains a good deal of confusion over the issue of lead agency status.

Health's director of learning disability services firmly believed that social services were the lead agency, although there was some hesitancy when asked whether this had been the right move:

"I suppose intellectually, yes. Personally, no. I would have... I think I would prefer that we had taken on the lead role, but I suppose I would have difficulty winning that argument, even to myself."

And this view was shared by some senior health staff:

"I think the health authority would probably view social services as lead agency... you know, that's the feeling I get at this point in time."

By contrast, social service's senior learning disability manager did not agree that his organisation had taken on the mantle of lead agency:

"No. We don't operate like that at all. We operate as a joint board and all decisions about services go through the joint board."

And gave a clear reason why this was the case:

"It was a conscious decision because we felt it important to recognise that one of the main areas of deficit for many people with learning disabilities was in fact health care. And for social services to be seen to be taking the role of the lead agency... there was a danger of actually pushing the social care agenda away from what is basically a primary health care agenda for many people. If we can get the primary health care bit right, the social care bit will follow."

Workers in the community teams expressed a range of opinions as to what had happened over the issue of lead agency status and the prevailing mood could be summed up as one of unconcerned uncertainty. Some did not believe that social services were taking the lead:

"No... I wouldn't say they've taken the lead. I think that's fairly... I think it's fairly well shared. And I think, in fact, in the past few years health have probably developed more services. So I don't... no, I don't think so. I don't think social services has been the lead agency."

Others simply felt altogether unsure about the issue:

"To be honest I don't really know who's taking the lead."

No-one voiced any degree of concern about the matter and the generally relaxed attitude towards this issue was summed up neatly by a health manager:

"I'm not sure it matters... as long as they get the services they need, I'm not sure it matters who takes the lead. I mean, I would have thought the best thing is for us to always work together where we can because we may have things to offer that social services haven't and vice versa, it depends on the client's need."

And expanded upon by another, who gave a specific reason why neither social services nor health could be regarded as lead agency for learning disability services:

"There are so many providers now within our services, we have lots of independent sector providers and charitable providers and we're working increasingly together, so that the local authority and the health authority have become smaller."

The confusion, at all levels, over lead agency status was clearly not something which caused difficulties between services or for individual workers. The truth of the matter was hard to ascertain. Despite the assertion from Health's Director of learning disability services that social services were the lead agency, other comments appeared to gainsay this and give greater credence to the social services' position that the lead was shared. A question asking whether there were written guidelines agreed between the two services which

defined the boundary between health and social care was answered by the Director as follows:

"We have a joint strategy now, a written joint strategy. And it's... some elements of it are enshrined within that, for example we've defined health care a number of different ways, if that's what you're leading to. But one of the aspects is really to agree demarcation on... cohorts if you like, erm... clinical cohorts. So we, as health providers, have taken the lead on three main areas. We've taken the lead on challenging behaviour/ mental health/ dual diagnosis issues; special care, by which we mean people with profound/ multiple handicaps/ complex needs and so on; and autism. So we've... we've taken the lead on those main groups."

Pooled budgets and joint management - area B

One reason for the apparent confusion over the issue of lead agency status was the fact that, at the time interviews took place, health and social services in area B were in the process of negotiating a unified learning disability strategy. This was to encompass pooled budgets and a joint commissioning structure, and possibly a complete merger of the two services. Although attitudes towards the incipient change tended to be largely positive they did vary between individuals at different levels in each of the current organisations.

Frontline staff from both health and social services, who knew least of the detail about what was being planned, were quick to point out the pitfalls of the current organisational split between health and social care, and felt that pooled budgets could help to resolve some of the existing areas of difficulty:

"I think it would be great for service provision if that could happen because then we wouldn't get the segregation that we get at the moment about people not being able to access certain.. certain day services, or it would be more difficult for them to access certain day services. And I

don't see how that could happen really if the money was all coming out of the same pot. So, yeah, I think it would be very beneficial really."

Moreover, they also appeared to believe in the inevitability of the two organisations eventually being merged into a single structure:

"It's my view that the learning disabilities bit of the trust will actually separate anyway and become merged with the local authority. That's coming now and we will be one learning disability service which will separate only adults from children, I would think. And even then that might change in years to come.. it would be one service from.. you know, cradle to grave."

Attitudes towards the proposals tended to be a little more circumspect at middle management level, especially within the health service:

"I think we would be looking to ensure that arrangements are very tight and that we know exactly what the financial agreements are. And I think we hope it's agreements, but it could be something different.. it could be a lead agency with a figurehead who's very dominant and comes in with a particular agenda and basically wants to control all the money."

Social service managers were also keen to keep learning disability monies secure. However, the concerns they expressed were those of protecting overall funds for the learning disability client group, rather than worries about social services losing power. It was pointed out that both health and social services' budgets were currently vulnerable to plunder by groups with higher political profiles:

"I think one of the things we want from joint commissioning is the ability to have ringfenced budgets, so that means when we go in we know how much is in the pot. Because in the past in social services.. one of the problems we've had in ***** has actually been services.. other services' overspend and there's been an expectation that people in the social directorate would help that. Er.. and, similarly, health.. the acute bit will overspend and end up stealing from us, but that's just been the national picture."

There was a more striking difference in attitude towards the joint strategy between the most senior learning disability managers in health and social services. The Learning Disability Service Manager in social services pointed to the progress already made towards a joint service:

"The changes that are planned and are in place is about joint systems between us and the Trust. So we've got £40,000 this year to fast track the implementation of joint management systems. We've spent the last twelve months developing joint reviewing and monitoring systems around individual cases. Erm.. we have er.. or I've got on my desk to complete after our meeting, a joint training strategy. We have agreed a joint programme. We are looking at a joint investment plan."

And went on to emphasise how this would feed through into improved services for clients:

"On the ground what I would like to see very quickly, though, is the removal of the boundaries between health and social care provision where funding is required to follow someone into a service. I see no reason why, if we totally remove the boundaries, a person with learning disabilities shouldn't be able to access any service whoever manages it. There is still an accountability issue at the moment, because we are two separate agencies with income levels and expenditure levels to match."

The Director of Learning Disability Services for the trust appeared more ambivalent. Part way through the interview the Director had stated that, rather than see senior staff moving freely between health and social servi

"I guess a couple of months ago I would have said the appointment of a joint commissioner. Erm.. things change, and today I would say erm.. the.. the maintenance of the successful joint working that we have, rather than the appointment of a joint commissioner and the whole joint commissioning.. you know, scenario. In some.. I come back.. you know, I go to the brink of that joint commissioning cliff every so often and then come back from it and think "Oh, we don't want any of that" (laughs). But.. you know, coming back from it I think "Oh, maybe that is what we should be doing, everybody says we should be doing it" The whole local government and Health context locally is saying "Learning disabilities should be a jointly commissioned service by April 2000" or, sorry.. will be (laughs). And there will be a joint commissioner in post to do that. Erm.. I suppose I feel that we do engage in joint commissioning now.. you know, without the necessity to move towards a single organisation with all the complexities of personnel and finance and so on that we will have to go through.. all of those hoops and jump over those hurdles and.. you know, it's going to be incredibly complicated, really, possibly to end up where we are at the moment, in terms of our service delivery obligations. You know, I'm not sure we'd be any better at the end of going through that process of becoming a truly joint commissioned service than we are as a joint working, or jointly this that and the other service. So that's.. that's a very mixed answer to your question. I don't know, really. Today I would rather that we slam the brakes on joint commissioning."

It was not possible to predict what would happen, but despite the reservations expressed about merger there was every indication that the two organisations were and would continue to work effectively together in the planning and provision of services.

Lines of communication - area B

One of the many positive effects of the simple organisational structures evident in area B was that it enabled communication, both within and between health and social service organisations. Staff from both organisations knew enough about the relevant structures of the other to collaborate effectively. Health's Director of learning disability services was confident of knowing the structure of social services:

"And I know it broader than social services as well. But I.. I mean, I can get to.. an appointment with the Director.. easily. Erm.. well, I think that says it all really. And I know erm.. in terms of the social services structure below him, who to speak to. I know the right people to speak to and I also know the best people to speak to.. and I know it very well.. and, I think, vice versa."

And other health managers used this knowledge when they needed to make contact with social services:

"I know some people who I've met through different groups and different bits of work, but if.. you know, if it was anything outside of that I'd usually go to ***** (the Director) and say "Look, I need to sort this out.. who's the best person to talk to?" I'd use ***** like that because I don't know particularly well their structures."

Some staff at middle management level felt that co-operation and communication was largely confined to the highest organisational levels:

"There's not a lot of.. of examples of us working together over the past few years except at perhaps the upper echelons of the structures. In the hands-on and operational management levels there's been very little working together."

But this point of view clearly overlooked the close working relations which were evident within the CLDT.

None of the social workers or nurses reported any problems of communication within the CLDT, but some doubts were expressed as to the effectiveness of communication between frontline and managerial staff:

"I think communication could be a lot better going in both directions really, erm... you know, with us passing our concerns up and them letting us know what's happening."

And frontline staff also voiced concern about their impressions of inter-organisational communication at senior management level:

"I don't know really how well management communicates with each other from the different services to be honest.. I mean, here we get some feedback. Although.. although feedback tends to vary from who you hear it from.. if we hear it from social services it may be different to the same feedback that we hear from health, for instance. So.. I guess it's because the people have two different agendas, they see the two things differently."

However, this may have had more to do with the differing management styles of health vis a vis social services rather than any actual lack of communication at senior levels. Social service managers described their organisation's overall management style as:

"Generally very consultative"

Going on to spell out how:

"We spend some time explaining to people, whether it's service-users or their carers or our staff, that there isn't enough money to do everything.. so that users need to be involved in er.. working on.. in identifying priorities, as much as managers do. Erm.. now that.. that leads to some quite difficult discussions and.. and debates, but what it does mean is that we tend to.. to have a very active consultation process around service priorities and service changes."

Whereas, by comparison, the overall style of health service management was variously described by the managers themselves as:

"Very pro-active"

and:

"Very rigorous"

There were some indications that less information was passed down the health hierarchy than was the case in social services, with at least one health manager believing frontline staff to be largely unaffected by the uncertainties over pooled budget and joint provision:

"I don't think it filters down. I think it might go to sort of team leaders, scheme managers.. who we talk to, who will ask us questions about.. you know, what's happening and erm.. I mean, again, I can only really say how we've relayed.. I mean, I don't think we relay information in a way that would cause panic or concern."

Despite these identified shortcomings in communication the larger picture remained positive, as summed up by this comment from social services' learning disability service manager, which indicated that not only was communication between the two organisations good enough to cope with constant structural change but that efforts were also being made to further improve communication at all levels:

"The Trust has just decided it's going to change its management structure around (laughs) so.. erm.. they're in a little state of flux at the moment in terms of their management structure but communication is good between us and in the beginning of the year.. next year, we're starting joint management meetings. So er.. we have joint management meetings at a senior level, but we're going to start joint management meetings at a fourth tier level, which will mean that people understand each other's roles a lot better."

Overall, the structural problems facing area B were minimal. Because the geographical boundaries of health and social services were coterminous and because each organisation had chosen relatively straightforward internal structures a situation had been created which was proving conducive to the promotion of close collaboration.

Chapter 5.2.iii

Comparison of organisational structures

Very different organisational structures were found to exist in each of the two research areas. These differences were evident in terms of both the operational divisions and the lines of management control chosen by each of the two health trusts and three social services departments. It was also apparent that such structural differences had a major impact in terms of enabling or hindering effective inter-agency links. The aim of this section is to briefly highlight the major structural differences which emerged and to begin to demonstrate the implications of these for effective co-operation and collaboration between health and social services in each of the two areas.

Service boundaries

The issue of service boundaries, and whether the geographical boundaries of health services were coterminous with those of the local authority, was obviously not an issue over which local learning disability personnel, from either the health or social services, had any control. It was, however, a fact of life that services had to cope with, and which played a significant role in determining certain aspects of individual organisational structure. In this respect the situation faced by learning disability services in area B was much easier than that which faced services in area A.

The health trust and local authority boundaries in area B were almost completely coterminous, meaning that negotiations between services were simple bilateral affairs. By contrast, in area A any potential co-operation between health and social services was instantly complicated by the lack of

geographical coterminosity. In practical terms this meant that area A's health trust had to negotiate with both city and county social service departments, and the county social services had in turn to negotiate with two separate health trusts (only one of which was included in the study).

Interviewees from both research areas commented that, although joint working often produced the best results, working solely within your own service was 'easier'. It is therefore possible that fewer attempts to co-operate were made in area A than in area B because the complex, overlapping geographical boundaries placed logistical demands on inter-agency co-operation which were even greater than normal.

Organisational structures

Like geographical boundaries, organisational structures were, at least to a certain extent, again determined by factors beyond the control of learning disability personnel. In both of the study areas the health services were shaped by decisions made at trust level and, similarly, social services were affected by the overall configuration of local government structures.

In comparing the two health trusts there was a marked difference in the degree of autonomy granted to the learning disability directorates. In area A the trust's learning disability services were headed by a Clinical Director, who managed health service provision but did not have complete control of purchasing decisions. This is significant since contracting to buy services from other providers is an increasingly important aspect of health and social care management. More and more services, which are accessed via statutory services' assessments, are actually provided by the private and voluntary sector organisations, whose services are purchased with public funds. In terms of

inter-agency relations in area A, this meant that health's Clinical Director was unable to negotiate freely over planned collaboration with either of the two relevant social services departments, since any decision which involved financial resources also had to be approved/agreed by the trust's purchasers. The ability of the Clinical Director to shape the service they ran was also further diminished by the presence of influential learning disability consultants who, whilst not having any clearly defined management role within the service hierarchy, in practice wielded considerable power.

By contrast, learning disability services in area B's trust were headed by a Director who had full responsibility for all managerial and financial aspects of the organisation. The second tier of area B's learning disability directorate's management included a business manager whose remit was to handle the financial aspects of service purchase and provision. This meant that area B's Director was able to negotiate directly with social services, and with other relevant organisations such as the private and voluntary sector providers. In this way not only was the Director the final arbiter of decisions within the learning disability directorate but there were in-house structures for handling purchasing contracts, rather than the final say and the all-important small print being managed elsewhere. Since in area B the role of learning disability consultant psychiatrist was limited to a purely clinical function, management authority and responsibilities were held transparently by the named management team.

The internal structures of the social service departments in each area, like those of health, showed a wide variation. Again, many of these differences derived from factors beyond the control of learning disability services. Since the 1998 local government re-organisation, area A had gone from having the traditional county-district structure to becoming two separate local authorities. The unitary status conferred upon the city meant that the social services department of this local authority was no longer subject to the complication of relating to two tiers of local government, and now covered a compact

geographical area. However, the legacy of the previous local government structures were still evident in the fact that there remained three separate CLDTs, two based in the same building and one a bare half mile away, which continued to operate separately, each providing a service to a defined geographical patch. However, apart from the somewhat splintered CLDTs, city social services did have a fairly straightforward structure, with the learning disability service manager encompassing both an operational and strategic/purchasing role.

For the rest of area A, the traditional local government system of district and county councils remained, and this was reflected in the structure of social services. This saw CLDTs operating on a district-based patch system, whilst all elements of purchasing and contracting services were handled centrally by the learning disability commissioning officer based in the county council head offices. What this structure appeared to have resulted in was an unfortunate communication gap between professionals in the CLDTs who were responsible for assessing the needs of individual clients and the person responsible for purchasing services to meet those needs. Since there was no systematic means of collating information from individual needs assessments and using them to inform purchasing decisions it was little wonder that frontline workers felt disconnected. They had no formal means of influencing purchasing decisions, but were faced with a situation where they had to fit clients into available services after having conducted assessments that purported to be needs-led. The rationale behind this system, in which there were no operational managers dedicated to learning disability above the level of the community teams, was to foster links across the breadth of adult services. However, there was no evidence from the interviews to suggest that any existing services actually provided for mixed client groups in this manner.

The structures evident in area B's social services, which was a department within a metropolitan county council, were similar to those in area A's city, in that there was a single tier local authority structure reflected in a simple social

service hierarchy. Like A's city social services and area B's health service, social service learning disability managers in area B controlled their own budgets directly and hence were again able to negotiate without intermediaries in the shape of separate purchasers.

All three social services departments were, of course, required to get financial and other decisions ratified by the appropriate council sub-committee, which sometimes caused frustrating delays in decision-making. However, there was evidence that social service personnel in area B took a more pro-active approach to relations with councillors than was the case in either of area A's social services. Perhaps as a consequence of this staff in area B were less likely to complain that councillors made decisions which were obstructive to the development of better learning disability services.

Community learning disability teams

The CLDTs in areas A and B were very different from one another in terms of size, composition and line management. The small teams in area A, each of which - whether answerable to city or county social services - operated on a local patch basis and a number of problematic structural/organisational issues were clearly apparent. The chief difficulty for area A's community teams, from which many others stemmed, was the lack of a clear line management structure. The other clear difference between each area's teams was that in area B the single large team spanned certain functional divides, such that some nurses and social workers were responsible for fielding new referrals, whilst others concentrated on assessing the needs of certain subgroups such as older people with learning disabilities or those from ethnic minorities.

In area A the team managers, all of whom were social workers by profession, theoretically line managed and allocated referrals to all members of their team,

although in practice the nurses were also managed by a nurse manager based in the local learning disability hospital. This not only meant that nurses were answerable to two bosses, but also that they received referrals from sources other than the team manager - namely from their nurse manager and/or from the trust's learning disability consultant psychiatrists. Thus the problems inherent in dual supervision were exacerbated by the powers of consultants to bypass the official CLDT referral route. In part a further function of the confused manager/medic role which the trust had failed to clarify, this was one of the most obvious way in which the powers of the consultants impacted negatively on inter-service relations. The upshot of this was that team managers were left in the unenviable position of being responsible for the team's work but not having control, or in some cases not having knowledge, of all the work being undertaken by team members.

Part of the reason that the community nurses in area A may have maintained such strong links to their nurse manager was that each of the small CLDTs usually contained only one nurse. It is likely these nurses felt more in need of regular professional support from their nurse manager because, unlike their counterparts in area B who worked alongside other nurses daily, they were working in an environment dominated by social workers. Nurses in area A were also noticeably more likely to express uncertainty regarding their professional role, more likely to complain that they were expected to undertake tasks which they considered to go beyond their professional remit, and less likely to be able to identify any differences between their role and that of the social workers in their team. So, whilst nurses and social workers in both areas accepted that their professional roles were in large part interchangeable, those in area B had found it easier to maintain their own professional identity without turning for support to elements outside the team. This confidence had enabled working practice, such as shared files, to develop which in turn helped to facilitate further collaboration on individual cases.

One of the few ways in which area A appeared to be structured more effectively than area B was in the diversity of professions represented within the CLDTs. In area B, where teams were composed solely of social workers and community nurses, almost nobody made reference to the involvement of other professionals, such as psychologists, speech therapists, occupational therapists, physiotherapists, etcetera. These professions were largely represented in the 'non-core' element of area A's CLDTs, and as such were not based in the team offices alongside nurses and social workers, but they did come together for regular team meetings. Although this study did not make any attempt to measure service outcomes, it would seem probable that this more inclusive approach to CLDT membership could provide greater opportunities for a holistic consideration of clients' needs.

Simplicity/complexity of structures

The most striking structural differences in services between areas A and B were the relative complexity of the organisational structures in area A and the comparative simplicity of those in area B. The positive effect of simple, clear lines of accountability and responsibility should not be underestimated.

In both areas, communication between health and social services appeared strongest at the upper echelons and at the frontline and somewhat weaker at middle management levels, which may be a function of the organisational roles undertaken at each of these levels. That said, overall communication and knowledge of the opposite organisation appeared much better in area B, where the structures were simplest. The importance of clear structures in enhancing inter-agency co-operation was, however, also evident in area A, where health service workers commented that they found city social services, which had a straightforward structure, far easier to relate to than county social services, whose organisational structures were fiendishly complex.

Many of area B's apparent advantages stemmed from the structural transparency of both its health and social service organisations. However, area A was clearly not the sole author of its own fate. Complications over geographical boundaries coupled with county's two-tier system of local government meant that area A's services suffered from the outset. However, it was also apparent that if decisions about the structures within each of the three separate organisations had been made which prioritised issues of inter-agency co-operation, then improvements in collaborative practice could be achieved.

Chapter 5.3.i

Human factors

The second of the three major themes which emerged from the interviews was that of 'human' factors. This is intended as a descriptive term to cover those aspects of services which are determined by neither organisational structure nor policies, but are created by the combined interplay of both these two influences upon the individuals who make up the workforce.

In this section the focus will centre first on individuals and 'personality clashes', examining both the causes and effects of such occurrences. From here the focus will then widen to look at group differences amongst health and social care staff. This will include looking at the various professional groups involved in learning disability and considering the impact that their separate professional training has had on knowledge and skills. Finally, the broadest possible view will be taken of how cultural climates vary within and between health and social service organisations, and this will be linked to differing ideologies of care.

Individuals within services - area A

At some point or another, in every interview, comments were made about the impact of individual personalities on the overall relationship between health and social services. Some interviewees took a very broad view of the multiplicity of factors which contributed to inter-service difficulties:

"I think it might be perspective sometimes, professional background. I think it could be the tension around resources. Sometimes it is personalities.. people just don't hit it off really. Sometimes it's over an

individual client, where people get on quite well generally, but sometimes it's about a particular situation that individuals have.. erm.. have difficulties around, whatever that is, or the agencies have difficulties around. Erm.. and sometimes it may be ideology-driven, it just might be. But.. you know, it's not just one factor really."

While another interviewee's response to the same question, about relations between services, placed much more emphasis on personalities:

"It's really hard to say, because for me it's.. it's partly just.. er.. it's partly my own biases that will lead me to say that a lot of it is down to people and whether individual people are relating well."

In this context, individuals were both given credit for when things worked well:

"I think there's also issues around personalities, that.. that individuals have chosen to make things work better."

and blamed when they did not:

"So I think some of the opportunities are there, but it's actually being able to use them.. which is down to people working together to achieve that."

It is perhaps significant that the above two quotes were both taken from the same interview. The manager concerned appeared to believe that, up to a point, their role was insignificant because the outcomes which were hoped for depended to such a large extent on the actions of others and were, as such, beyond management control.

Other managers expressed themselves even more bluntly:

"I do think that personalities are really key.. really key. Because you can have the same ideological viewpoint about things, but if you've still got two individuals who'd have to sit down and make the decisions about that (co-operation), and they hate one another's guts for whatever reason, you're not going to get it happen."

And some gave examples of how they felt individuals and personalities had both helped:

"I mean, I think things changed a bit because of the appointment of certain personalities."

and hindered the development of effective collaboration between services:

"For a long time we've had a ***** who has continually proverbially stuck two fingers up and said `Well, I'll go through the motions, but that's that.` Whereas I think we've just got somebody new and it will be interesting to see if it changes."

One theme, which ran through many of the comments about personality, was the belief that individuals in certain positions could greatly influence services:

"I think so much does depend on personality and it's people in.. in key posts that can affect the way an organisation operates."

Some appeared to believe that the existence or otherwise of such charismatic leadership was largely a matter of chance:

"I suppose having moved around a number of different places, between X and Y and Z and here, erm.. my impression about how health and social services work together is that it does seem to be very, very patchy and very locally-determined according to, erm.. if it works, it works because one or two key people in powerful posts are able to drive it through. And if it doesn't, which is most of the time, it doesn't."

Other managers themselves took responsibility for influencing whole organisations. So, again taking two quotes from one manager, in this instance both the blame and the credit for inter-service relations is located within the confines of senior management:

"I think relations, particularly in the sense of between management teams, has become more problematic (since the CC Act). But that gets felt lower down the organisation."

"Well, I think ultimately.. I mean, everything has to be underpinned by the willpower of, and the will of, the top teams. So lots of very practical things that we try and get going and try and keep going are things around

joint training. And some of them are around culture. And some of them are around practice."

However, although most managers agreed upon their own importance, their views about how hands-on staff related to one another varied considerably, from a blunt:

"I still think there is a lot of in-fighting at a lower level."

to the more cautious:

"I think people on the ground would say to you on a day-to-day basis they all work along fine together, there's been hiccups here and there but they work.. they work okay. What they'd say privately, of course, I'm not too sure."

This was especially interesting in the light of comments by staff from both health and social services about the importance of face-to-face contact in the promotion of co-operative working. One CLDT Team Manager saw such contact as vital:

"I don't think there is any substitute for erm.. you know, face-to-face.. the relationship that you create face-to-face. I mean.. I think.. you know, you minimise that at your peril really."

but a senior health manager acknowledged that this did not always happen at every level:

"I think it would be helpful for key people at each level to know each other, to have met perhaps face-to face. That doesn't actually happen, so some people still only link with their counterparts in the other department via the telephone. And that isn't always the best mechanism."

As a whole, staff above the level of CLDT Team Manager showed little active awareness that people working in such teams tended to have better relationships with colleagues from other professions than was always the case at higher levels. One Team Manager summed the situation up by saying that

"At operational level people are.. have to work together and.. you know, and kind of hammer it out."

And another attributed the success of their teamwork to having shared outcome goals:

"But we have.. we sort of say 'I wonder why? Why is it?' (that team members work so well together).. you know, obviously personality comes into it, but I think overall it's the fact that they see the client as the main focus of their work and they're all prepared to do whatever it takes to get the best for that person."

Most teams appeared to work in relative harmony, with only one person willing to admit to any degree of dysfunction within their own patch:

"I should be diplomatic on this, but things within the office are not always that good.. with sort of personalities and individuals. I think that can sometimes make it more difficult. I would actually like to work in other teams to.. to discover what it's like myself, because talking to my colleagues I certainly feel that other teams work.. differently, or probably more closely should I say."

And even this sentiment was tempered by a rapid disclaimer:

"I actually have good relationships with those within the team, but there are other issues which happen within the team which make it difficult."

Which gave the impression that the team's purported difficulties might be rooted in structural or operational problems and had simply found an outlet in what were then deemed personality clashes.

When asked directly whether they believed that personalities or organisational structures were more important in creating effective services there was a rough split of two-thirds to one third in favour of personality being the crucial factor. The logic as to why personality was more important tackled the subject from both sides, arguing both that:

"You can get around some of the difficulties of organisational structures if the individuals involved have a willingness to get around them."

And that, regardless of legislation or structure:

"If you've got people that don't want to work together, they'll find ways of not working together."

Both of which lines of thought could be viewed as examples of fundamental attribution error, although the following argument in favour of personality was harder to dismiss:

"I think the personalities.. you know, probably the reality is that they are probably more important than the structures. Erm.. because I think that the people who have been around long enough here... .. see structures come and go and come back again and go full circle so many times that I think, in a way, people can allow for that.. at certain levels can allow for that and just carry on doing the work."

This statement could be regarded as evidence strongly supporting the concept of street-level bureaucracy, demonstrating as it does the apparent unwillingness of individuals to change their work practices even in the face of significant structural changes within their organisation.

Those people who did feel that structures were more important than personality exhibited some interesting lines of thought. The first was the idea that structure was the primary, and personality the secondary, force in operation:

"I think the dominant factor is probably organisational and structural issues, erm.. but there is a.. a.. you know, a minor factor there of personality. That, and the way people operate within those structures and organisations, I think, is.. is significant at some points."

Which gave a sense of how structure perhaps determined the degree to which personality was allowed to come into play.

A social worker, who was reflecting upon how well his team worked together compared to what he had heard of other teams, was unwilling to give credit to personalities because this belied any hope that other teams could adopt more effective working practices:

"You would hope that it wasn't just down to personalities and things like that.. that there is perhaps a regime of working that hasn't been set up for other people, but could be."

And a nurse identified stress in the workplace as one of the reasons people mis-identified structural problems as clashes of personality:

"And.. you know, what happens when you're under stress is, rather than looking at the system that's creating the stress for you, what you do is.. you know, you.. you lash out at people."

Again, it was notable that those best able to express the significance of structure over personality were workers at the sharp end, rather than those at the top who had more chance of influencing structural change.

Professional groupings - area A

In addition to the effects of individuals upon services, issues also arose concerning loyalty to, and friction between, the various professional groupings. Obviously, the simple fact that two distinct organisations are charged with creating a single `seamless` service creates difficulties in and of itself. But beyond the structural problems which have been analysed earlier there were also concerns about the suitability or otherwise of certain groups to perform the required tasks.

Several senior health workers based their opposition to social services becoming the lead agency for learning disability on the premise that social services as a whole lacked expertise:

".. particularly around more challenging clients."

Although there was also an acknowledgement that this was:

".. a skills training thing, it's not somehow inherent in having a health qualification."

And a suggestion that this situation could ultimately be rectified:

"I would separate it off between being the lead purchasing agency and the lead providing agency. Because obviously, in provision, they do need to have the expertise and I think they would say they don't have it. Following that through logically I don't see any reason why they can't acquire it."

But another health manager drew parallels between the skills gap which social services were currently trying to bridge and a similar one which had been ignored within the health service itself:

"I think, to be honest, there was a lot of naivety about the.. the transferring of health service staff from institutional settings into community settings and not realising the huge personal and professional development and induction needs that were needed, and largely I don't think those were ever attended to."

Inevitably, within the CLDTs, there was debate around the relative skills base of social workers as compared to community nurses. The consensus of opinion from the nursing fraternity was that their specialist training gave them a superior understanding of the needs of people with a learning disability:

"Having recently interviewed a number of social workers for a post it's quite obvious that their awareness of learning disability needs are not as acute as say a nurse, for example, who's trained three years specifically on working with someone with a learning disability."

"Social workers come from, or generally come from, a very generalist social work background, erm.. and may not have specialised in learning disability at all and.. and learn on the job. Whereas we've had some formal training in learning disability work."

That said, nurses were also willing to recognise the value of social work education:

"The training that people receive as social workers gives them the skills to be flexible and to be.. you know, aware and incisive."

And to acknowledge that some of the skills gap between nurses and social workers was forced by structures rather than inherent in the abilities of their CLDT colleagues:

"The (CLDT) teams won't work.. the social worker team won't work with people with a mild learning disability. So that means that probably the consultant and the community nurse are left to work it alone, which isn't.. which isn't always useful. Or have to work it with an adult care team who have no specialist knowledge."

For their part social workers appreciated the technical skills of their nursing colleagues, but felt that they too had particular skills in relevant areas:

"I think one thing we're bloody good at in social services is doing assessments, actually. And I think it's a skill which.. you know, we're continuing to develop and acquire. I think it can sometimes be seen as a bureaucratic process. It would drive health colleagues mad doing them.. you know, they want a decision there and then (snaps fingers) and erm.. but, yeah, I think we try.. we make determined efforts to get alongside the clients and try and find out what they need."

From all CLDT staff there was a wish to make their position understood and abilities apparent, but an equally strong desire to acknowledge the distinctive yet complementary nature of the roles undertaken by other professions. A Team Manager also argued that it was of benefit to maintain these separate professional identities:

"I think social work has a role, I think.. you know, it is carrying out assessments. You do need a sort of multi-disciplinary approach. Because people have so many facets of their life you need different sorts of people, who have different skills, to be able to assess those elements of those lives. And I think the creation of, like, one super-universal worker is not necessarily the way forward."

The differences between professions, on the basis of both personalities and skills, was noted:

"You could argue that.. you know, nursing and medical courses attract a different type of person to social work courses, so you already start with huge differences."

But these differences were not allowed to eclipse the benefits of multi-disciplinary teamwork:

"I think that's made use of various characteristics of other professionals, either by way of their training or even by way of personality and character.. individual skills which can be learnt but sometimes are.. are just inborn skills. So I think that's the positive point of the multi-disciplinary work here."

Organisational cultures - area A

To a certain degree the distinct cultures in health and social service organisations can be viewed as an extension of the differences already described between the different professions. Although professional training may equip individuals with differing skills bases, this was generally regarded as beneficial within a multi-disciplinary approach. However, as well as teaching certain skills, professional training, whether overtly or otherwise, also instils into its students an ideology which will underpin future professional decisions.

For some of those interviewed these ideological differences were one of the key problems to be overcome in order for effective co-operation to be achieved:

"I think one main difficulty is that there seems to be a sort of.. the philosophy of care and the professionals involved seems to be different."

And that will always occur where services agree to work closer but then there are sort of different kinds of professionals trying to work together. And then the.. I mean, that leads to clashes between ideas and.. what are priorities."

Others denied the importance of ideology:

"I don't think it's ideological, but obviously people start at different points.. you know, from a nursing background, from a social work background, or whatever."

Or viewed it as a kind of dangerous political aberration which governments might try to impose upon unwary public services:

"If they want to go down the clinical governance path we'll be fine. I've no.. no problem with that. It's if somebody's trying to impose something for the sake of an ideology then we're in big trouble, because the ideologies don't work. If you have them there, you're a pawn."

This might, in part, to be a reaction to the use of the word 'ideology' in the interview questions. Many interviewees seemed to find it easier to talk about culture, rather than ideology, although arguably workplace culture is no more and no less than ideology expressed through professional practice:

"I think that the culture of the organisations is different. And I think that part of the difficulties they have in working together is a sort of an NHS culture and a social services culture."

There was some evidence that closer working practices had helped to draw together the gap between health and social services. One long-serving member of social service staff could see an improvement over the years:

"Yes, organisational cultures, certainly at the beginning, was a very big issue and erm.. I'm not saying it's resolved (laughs), but.. but I think there's a bit more understanding than there was."

Whilst a recently appointed health service manager was unaware of any division:

"Ideologically I think that, or I feel at the moment that the key players are all.. all have a similar viewpoint."

One of the only unashamedly ideological discussions which some people were happy to enter into was the ongoing debate over the relative merits of medical models of care as compared to social models. Even here, there was as much said about whether this division actually still existed as to what it now constituted. One CLDT Team Manager was adamant that this remained a live issue:

"Obviously you've got a medical model still, in many respects, versus social model of care. And it feels like there's one hell of a way to go, really, in many respects."

While another believed it be on the wane:

"At one stage I think things were very polarised between sort of a health model of disability and a social care model of disability, but I think there's been a lot of sort of meshing of that."

It was only really the consultants who approached the subject directly, and even here there was some suggestion that a new hybrid was being created from old doctrines. One consultant emphasised how social models had altered over time:

"The social models that were around really denied impairments, not physically.. it's easy to deal with physical impairments, but it's the mental and social impairments. And they're pretty.. they didn't fit into the model, it's was your responsibility for not learning or refusing to learn or refusing to understand that what you did was wrong and not be sorry about it. And there are severe limitations to that model.. but we are moving to create a better model. And certainly on the ground, working in the community, I feel we're sort of.. I can talk about impairments without having my head bitten off."

And another appeared keen to see the positives and pitfalls of each approach:

"Probably they have a wider view of disability than health, which tends to construct it in a.. not necessarily a medical model, but tends to have a kind of health-formed construction on it. So in that sense I think the

benefit is that wider view of persons with learning disability in society, and I think one of the costs is that some people with the most intense needs probably don't get their needs met as well as that should or could."

Interviewees were keener to deny that their work was in any sense ideology-driven than to discuss the merits or otherwise of any particular ideological stance. Thus from social services came the declaration that:

"I'm essentially a pragmatic manager, I think, because otherwise you'd never survive."

Which was then echoed from within the health service:

"There've been a number of us on both agencies who think in that pragmatic sense, but who are also prepared to think around what.. we think pragmatically, rather than ideologically, and are prepared to think around problems."

When the terminology of cultural, rather than ideological, difference was adopted more people came forward with opinions. Some of the views expressed emphasised how cultures varied as much within as between organisations:

"Health isn't unitary in terms of its management style or organisational culture. I think there's.. there's all sorts of variations within health, and probably similarly within social services."

In particular, the difference between community-based and hospital-based services, rather than simply between health and social services, was highlighted:

"I think, with the health staff that work in the Community Learning Disability Teams, they will clash as much with the hospital site's culture as some of their social work colleagues. Or our staff that work in the community group homes, they'll say `Well, you can't just lock a door`.. you know, that you have no right to restrict someone's liberty, and.. and there is a mutual clash of those cultures as much as there is between health and social services."

At least one senior manager felt that the legacy of hospital-trained health staff was still being felt within newer community-based services:

"Social services, whilst they have got their own mini-institutions, one could argue.. such as day centres and residential centres, a lot of the thrust of social services is working with individuals in their own settings in the community. Now, a lot of the health service staff who joined community teams were health service staff whose actual formative experience had been in larger institutions. Erm.. I always felt that was quite a.. difference, a formative experience. That if you have always worked as it were in the community, and see the focus of your work being in the community, you approach things slightly differently than if you have only seen the community as somewhere to which people might go to from a larger institution."

However, this belief was not reflected in any of the views expressed by CLDT members.

Where there were, however, signs of an acknowledged ideological rift was between statutory and non-statutory services, with voluntary sector organisations coming in for particular flak. Senior hospital-based health workers were more likely to criticise voluntary services than social services:

"Ironically it's some of the voluntary sector places I'm a little bit more worried about, because their philosophies are so tight on.. on a good normalisation model, that when it's starting to fail they're completely at sea. Whereas I think social services is a bit more war weary 'cos they've had a few more difficulties."

Some were able to see structural reasons why this was likely to occur:

"I think that, in both health and social services, that the sense of pragmatism and the sense of there being a wider spread erm.. experience of testing ideologies out, meant that fewer single units remained if you like ideologically separate or cut off."

But others remained steadfastly unaware that the medical approach was itself an ideology, whether openly stated or not, and appeared frustrated that their diktats were not always embraced by voluntary sector organisations:

"Sometimes, I.. I would say it's always with the voluntary sector, where the voluntary sector will not do.. you know, will not follow the treatment plan because it gets in the way of their philosophy. To me that's idiotic, isn't it? But I don't think that that's so much so with social services."

Only one person directly identified the link between ideology, patterns of work and conflict between organisations:

"There is a difference in ideology, certainly. Erm.. but I think sometimes the difficulties.. and maybe coming out of that, are to do with patterns of professional practice and expectations rather than ideology about the client group."

But many, many people gave examples of how different work practices, derived from what appeared to be a combination of professional ideologies and organisational structures, created difficulties for co-operation:

"I think there's slight differences in terms of.. well, the culture of supervision. I think nurses.. see.. you know, if you're a grade G nurse you're autonomous. But if you're a level £ social worker, which is about the same cash, about the same level of responsibility, supervision is seen as part of the deal."

"I mean, social services have a much better-established system of supervision, one-to-one supervision for all staff. So that's just built into the system. It's not in any way about taking away professional autonomy, it's actually about recognising that most of the work that social services does is done by people who are vulnerable and where most of the work is actually a human interaction."

"The one thing that I would think is different is that health are very keen on audits and measuring effectiveness and those sorts of things. Which.. erm, talking to colleagues, they find quite interesting but very

difficult to manage and to actually fit in with the work that they are doing anyway."

"I have always found the social services structure a very complex, bureaucratic body. Likewise, I'm sure they'll think, the health structure. And what I found very, very, very frustrating was the fact that.. because I'm a health person in a social services team, is the total bureaucracy of it all."

"I'm not quite sure about the bureaucracy thing really. I sometimes think there's a pile of bureaucracy piled on us in social services and maybe health are more able to move. But I'm not sure whether that's true, because I think the democratic process within Local Authorities puts a different emphasis on how you work."

"There are different cultural things.. I mean, I think I.. I often say sort of jokingly 'I don't think I could work for social services, I'm not PC enough'."

"I think health is more.. bom - bom - bom! I mean, I think that's how I'd describe it. They make decisions and suddenly something's changed, and I.. and we'd probably be seen as a bit of a lumbering carthorse sometimes, and.. and they make decisions. And I think that.. that causes tensions."

Running alongside this tacit acknowledgement of ideological/cultural difference was an admittance by some that once a culture had developed it could be very difficult to alter. Unsurprisingly it was those who had been in their posts for shorter periods of time who showed the most enthusiasm for change:

"People's lives could be enhanced, but it's about taking risks, people being encouraged to take risks, managers allowing people to take risks, being prepared to.. you know, take the risk and the consequence of that. Not being frightened, not individualising it. Erm.. I mean, obviously there's a balance to be.. to be had there but, in a way, the services and some of the vision within the service is still just very old-fashioned."

And longer-serving staff were more likely to explain rather than challenge the inertia:

"I've always got a fire-fighting sense from the service, in that everybody runs around, works extremely hard on all levels to provide a service as best they possibly can for the client group, and by definition that has never.. or that has allowed little free time to be able to do all the other stuff that then enables you to expand, or bid, or whatever."

Only one person mentioned the wider socio-cultural context of the work they were doing and how that could perhaps induce divisions between professionals. His comment seems worth repeating:

"I think.. you know, social care is never going.. you're never going to see the Sun headline `My Social Worker Saved Me From A Life Of Misery`. It's never going to be popular, it's never going to sort of have the.. the appeal of nurses."

Maybe this, as much as anything, explains why individual, professional and cultural divisions apparent between health and social services in area A remained so stubbornly indissoluble.

Chapter 5.3.ii

Human factors

Individuals within services - area B

It was clear during the course of interviewing that both intra-organisational and inter-organisational relationships in area B were generally harmonious. This was apparent from more than one angle. That is to say, there was evidence both that personality clashes were not a major source of conflict between health and social service organisations:

"Personal issues comes low down, there are.. they are generally a very professional team across the board."

and that, in fact, individual personal relationships had done much to promote co-operation:

"I think some of it's through personalities.. I know *****'s been working very closely with social services over the last year and I think probably that's spurred it on."

Within this, it was also apparent that some of the longer-serving staff in area B were aware that there had been times when senior managers had had less productive relationships. So the CLDT team manager spoke of inter-service relationships as having:

"... improved recently. There was a period when the community trust had introduced a new Director of Learning Disability, who came in with the task of closing ***** Hospital down. He was very focused on doing that.. .. wasn't an easy man to negotiate with in terms of relationships between social services and the health trust."

However, the two current key players from health and social services worked closely together and this fact was acknowledged by their staff:

"My impression is that the two managers who have if you like pursued this particular process.. this collaborative process, and started working together have done it equally. I've not got the impression that one's been dragging the other."

That is not to say that there were now no problems with individuals. For example, the issue of professional supervision for community nurses appeared particularly fraught, with social workers commenting:

"I really I feel they should be getting better professional supervision outside the team. I don't think they er.. particularly value their professional supervision, but that's to do with personalities."

"I don't know anything about the nurses' management apart from.. I mean, they're always having a pop at him, they've got no respect for him whatsoever.. they're incredibly rude about him actually."

And a nurse echoing, rather more guardedly:

"Yes, personality clashes. I don't think that's sort of health versus social, that just more.. that just.. I mean, there's probably more personality clashes within the nurses themselves than there are within the team."

On a more upbeat note, there were also expressions of belief that individuals could have a positive influence on services. Health's Director of learning disability services felt that part of the reason for the interest in this client group from the wider social services' hierarchy was due to the fact that:

"We have in ***** a Director of social services who's worked many years of his life in learning disability services in other parts of the country, and is very committed to them."

The thought that senior staff could influence the attitudes of others was also seen elsewhere. The nurse who made up one half of the C.O.R.E. assessment team within the CLDT spoke of the ambassadorial element of joint working:

"***** and I represent both organisations and we're both well known around services because we've been here a long time.. we're fairly high profile." ... "So if people see us working together that's a good model, that's.. that's good role-modelling for people to be able to look at and think "Oh.. they work together.. strange, but they do" and.. and I think that's helping."

Although there was no hard evidence of the effect of such role models, it was noteworthy that every member of health staff interviewed mentioned their Director by name at some point. These mentions were all either positive or neutral in tone, and can be thought to hold some significance since this effect was not found in any other organisation in either area.

Bearing the above in mind, it was also interesting to examine the responses to a question asking whether individual people or organisational structures were more important when it came to creating good relations between services.

Health's Director was particularly vehement on this point:

"Personal attributes. Yep. The organisational structures are irrelevant when it comes to successful joint working in that way, erm.. completely irrelevant. They can be made to make it work better or to hinder it, but they are largely irrelevant. So.. I mean, this is in contradiction to what I said earlier about the broader political policy context, which gives you the reason to do something. When it comes to doing something you need to find the right people."

Other staff from both organisations shared a more evenly balanced view:

"I'd say it's down to the personalities, really, rather than the structure. I think one or two people can very much.. you know, lead the way, irrespective of the type of structure you've got. But I think the structure is quite important in.. in continuing to deliver the service. So I think in terms of.. you know, influencing up front and establishing what need

there might be and looking at developing the strategy it's possibly down to, certainly in *****.. you know, three or four people. But I think the structures in place perhaps are more important when you talk about implementation than the sort of initiative bit."

"The structure or the people..? Well, it's not as.. it's.. I mean, it's a combination of both because in some cases it's personality, in other cases there might be.. and that's usually.. and that's negative comments.. someone who has difficulty erm.. negotiating, even within their own department let alone across a departmental divide. And people have their own erm.. what's the word.. trying to build their own empires, yeah.. feel very insecure. And there are people like that around, I know that.. but of course that's just in health, that's not in social services (laughs)."

Whilst a lone voice spoke out in the belief that organisational structures were more important than the individual personalities who worked within them:

"Organisational structures are far and away, far more important. You need organisational structures so that people know what they're doing, how they're supposed to do it and who they're accountable to for doing it, and that they are given good information about.. given support and help in doing it properly. And only organisational structures will do that. And that means that when people fail to meet the right standard the structures help the organisation to be able to deal with that as well. So that erm.. you have clear systems for dealing with any eventuality."

Obviously there is no simple, or definitive, answer to the question posed and no such clear response was expected. However, despite the widely varying views on this point it was evident that, in the health service at least, structures had carefully been put in place which minimised the potential negative impact upon services of obstructive individual actions:

"When we built, for example, our infrastructure of residential care and day services we developed concepts of networks and we said an essential part of a network is that there should be freedom of movement within that. So if you have, say, eighteen day centre settings such as we have

erm.. we knew from history that.. put the wrong person in charge then either they would select only the people they wanted erm.. in perpetuity, so.. you know, we certainly didn't want to repeat that mistake. Hence we made this network arrangement and we took the decision-making for progress through the network to another level, to an allocation team or something like that.. more senior managers. So referrals were made to them, and then on the basis of the need.. you know, the resources would be allocated. So.. yes, this person is going for three sessions a week to your place, okay? It's not your decision whether or not they come in and out."

Perhaps area B had been fortunate enough to have had managers in place who were both skilled at building trusting relationships across the health and social care divide, and realistic enough to know that while individuals could help create good services it was necessary to put organisational structures in place to ensure that the next person who came along was not able to undermine any progress thus made.

Professional groupings - area B

Although many different professionals are involved in learning disability service provision, the two key groups working with this client group are learning disability nurses, largely employed by the health service, and social workers employed by the local authority. As individuals, and as a community team, the nurses and social workers in area B appeared to co-operate effectively, but this did not completely negate the power of long-held beliefs about the 'opposite' profession. A key area of debate concerned the relative expertise in learning disability matters of each profession.

The most damning comments, which were claimed to be views espoused in the past rather than the present, came from nurses and concerned social workers:

"From a health service point of view I think.. I think we've tended to look down on local authorities, since we've a rather elitist view that they aren't properly trained, properly qualified and whenever they have problems they tend to consult us. And that's a very elitist view, but that I think is an honest opinion of.. of how we in health have perceived providers in local authority services."

But this view was not repeated elsewhere and the following is a more typical nurse opinion:

"I've worked with nurses and I've met people from social services and I'd say many of the skills and many of the erm.. things that they lack are maybe the same."

The other way around, complaints were scarce. The closest any social worker came to complaining of a skills deficit amongst nurse colleagues was when talking about how assessments were conducted:

"Maybe if nurses.. if they were more skilled at identifying what is a social work task, then that might be easier. But whether that's down to them or down to us.. I suspect it's probably down to us to explain when to refer to us, as opposed to not."

Differences between nurses and social workers were, however, more frequently ascribed to different approaches to their work, as ingrained during training, than to a skills imbalance. A social worker asserted that:

"I do think training has a lot to do with it. I think the way in which individual disciplines are trained has a.. has a lasting impression on how you work and what you're trained to look at and what you're trained to do."

And also noted how:

"Health and social services, historically, have had a completely different sort of training, different sort of background. I think.. there's the old joke isn't there, most social workers are either religious or socialist (laughs)."

Whether or not there had been any significant change in the training of nurses and social workers, which might help to break down barriers between the two groups, remained a moot point with staff espousing various beliefs:

"I think the way that.. well, the way that both nurses and social workers are trained has changed, so it really is quite different. There doesn't seem to be the same tensions that there was between the professions."

"Some of the very newly qualified nurses have trained in a much more social care model than.. than the ones maybe twenty or thirty years ago. So I think nurse training's changed. I'm not aware that social working training's changing very much."

And the social service manager believing that inter-professional differences were a bonus rather than a difficulty:

"I'm a firm believer in separate training for health, education and social services, because I think that actually gives us a better skill mix."

.. a view which found its echo in the increasing specialisation within the nursing fraternity:

"At one time we were just learning disability nurses. Now we've got people specialising in working with people with multiple needs or with challenging behaviour and people doing more and more qualifications."

Organisational cultures - area B

Whether or not professional training and skills were at the root of it, health and social services currently maintained separate and distinctive organisational cultures. Workers, even of long standing, found that actual joint working across services entailed a steep learning curve:

"It's a bit of a culture shock both ways. I mean, I struggle with erm.. with the much more sort of like disciplined decision-making set-up that I

think's in the health service and I think vice versa. I think for individuals it can be a bit of a culture shock, definitely."

And every person interviewed was able to identify what they felt were cultural differences in the attitudes and working practices of each organisation.

When asked to describe their respective organisational cultures, the senior managers of health and social services in area B gave quite distinctive replies. For health the emphasis was on doing and adapting:

"I would like to think it was sort of like developmental.. there was a developmental culture here. So that there was a feeling that it was an evolving system, it wasn't static, so that people felt that there was a potential for growth and change within the systems and the services, always. We've tried to generate that view."

Whereas social services chose to stress the importance of listening:

"Generally, very consultative. We want the services to be very much based around the needs of people. Erm.. we spend some time explaining to people, whether it's service-users or their carers or our staff, that there isn't enough money to do everything.. so that users need to be involved in working on.. in identifying priorities, as much as managers do."

Interestingly, there were many echoes of these management points of view in the comments of other staff. The less consultative approach to decision making on the part of health was seen by social services as a possible cause of conflict:

"The health environment.. retains some of its old hospital orientation, in a diluted form. There's much more hierarchical management, less consultation and certainly as we move towards working closer together er.. those become issues, because from a social services aspect we say "We have procedures for going out and consulting with people about changes in service" and the trust is very used to.. making a decision at eight o'clock in the morning and implementing it at nine."

But health staff were equally concerned by what they saw as social services' diffused decision making:

"I think they spread information a lot more widely.. you know, they have a bigger sort of team.. you.. you know, it's not as tight, it's not as focused, there are more people know what's happening, I think. But I don't necessarily see that as a positive thing, because I think sometimes.. you know, if people know too soon.. they know before a decision has been reached and it just creates unrest."

Comments from social workers confirmed that they, too, recognised the degree of discussion which took place in their service. But although some viewed this in a positive light:

"In social services you have a debate about you're doing. And I know that creates all sorts of jokes about how many social workers does it take etcetera, but there's a much more of a democratic decision-making culture, I think, in social services."

Others appeared less enthusiastic about the process:

"Changes seem to come very slowly. And they're talked about, and they're talked about and you think.. well, I'll believe it when I see it.. you know. And then you start to forget about what's even been talked about."

This emphasis on consultation within social services was partly a result of the structures of local government and partly a consequence of client factors:

"Health services aren't as publicly accountable as us, for a number of reasons. I mean, firstly they don't have the political accountability, secondly their service users don't have the same level of carer involvement, but thirdly they're not as used to operating in the community as we are."

And, again, whereas social services saw it as positive that:

"We have much more Union involvement, we have accountability to Members, we do forums with users and with carers."

Health managers were more inclined to view these as behaviours born out of necessity:

"I think they're far more democratic in style because they've had to be.. you know, really because of the heavy influence from the trade unions associated with local authorities, that we've not had in health."

When it came to talking about their own organisational culture, health staff chose to emphasise their strong managerial control:

"From the top we.. we demand knowledge of everything that is going on all the time.. particularly in relation to key areas of human resources and finance, but also in relation to any aspects of client care. Where there are irregularities shall we say, or problems, there is a very fast track."

And to contrast their own perceived efficiency with social services' allegedly more lackadaisical approach:

"Their culture is not one of discipline, whereas ours in the health authority is much more so. We.. we find that their attitude can be somewhat laid back and they don't seem to appreciate some of the rigours that we've worked under."

"I think we feel we're more efficient.. a lot more efficient. But.. maybe we're wrong, but I think that's how we feel, that we've sorted out a lot over the last few years in terms of closure of the hospital, etc and er.. I think we feel they're maybe not quite as pro-active."

[social services are...] "Oh.. oh.. really, erm.. (sighs) laissez-faire, very laissez-faire style."

From a social service perspective, health's self-styled efficiency and rigour was unsurprisingly viewed somewhat more critically:

"Social services are a lot more softly-softly, feely-feely and we sit and talk to people, we talk to our staff, we.. you know, we.. we don't jump in with the big boots flying straight away."

"I think in the health it's a hierarchical structure.. people are used to doing what the management says and without.. I don't mean without

questioning, I don't mean slavishly following, but there's much less of a questioning culture."

Overall, however, the most striking feature about the comments on organisational culture was how much common ground there was. Health and social services staff could all describe both their own culture and that of the opposite organisation, and did so in remarkably similar terms. Where they differed was in their analysis of the benefits or otherwise of each approach.

Differing beliefs about how services should be run inevitably caused certain difficulties when health and social services were required to work together. However, there was some evidence that the process of co-operation was changing entrenched views, with the result that a positive cycle of shared cultural understandings had begun to take hold. Thus health workers were able to admit that social services did not simply 'babysit' clients:

"As there's been some more.. some more harmonisation of services it's given us on this side a chance to see that perhaps it wasn't quite so rosy on their side, that they were dealing with people who did present them with a range of challenges."

And social workers found less conflict within the CLDT:

"I think they found it hard with us social workers, because we tended to question everything before we took action, whereas nurses would say "Right! A job needs doing and we'll do it!" and they'd just roll up their sleeves and go straight out. Whereas we would sit around wasting our time, as they thought. It's not like that any more, but that was the early days."

Although it was also acknowledged that some degree of cultural divide remained:

"I think we always feel more comfortable with the culture that we've been if you like brought up with.. or trained with."

"What we don't share is a shared mission or value, they haven't come together yet. We ... we talk along the same lines, but we don't act and behave along the same lines."

The other key issue concerning organisational culture in area B was that of ideology, or rather the apparent lack of it. Although the interviews included such questions as "Is there ever any conflict between health and social services over ideologies of care?" and "Are there noticeable ideological differences between health workers and social service workers?" only senior staff felt confident enough to comment directly on ideological issues.

Of these only one person was willing/able to identify a clear ideological difference in the approaches of health and social services:

"I think also, ideologically that there are differences anyway in terms of.. I think nurses like to do things for people whereas social workers like to get people to do it for themselves, or make choices about what they want to do. So at the end of the day our approach is different and our.. what we see as the outcome of our intervention would be different. We want to cure it, whereas social workers don't necessarily want to cure things they just want to allow or enable things to happen."

And the senior managers who had described such differences in culture, which must surely be the practical outcome of an (albeit unspoken) ideology, were unanimous in their conviction that ideology was not a cause of conflict when trying to co-operate:

Interviewer: What causes conflict?

"Ideological issues.. some, but not a lot because we've actually spent a lot of time developing joint policies and statements about what we feel services should do and those are about empowering individuals."

"There is no ideological conflict now. Erm.. and I'm not sure, really, there were ever.. it was ever very deep when it was there before."

The reason for this apparent mis-trust of the term "ideology" was unclear. It may simply be that it was felt to be too political, although there was spontaneous use of the term when it was able to cast a positive light upon learning disability services:

"My view is that learning disability services are always.. they've always been at the leading edge of things, they've always been the ideological leading edge.. erm.. way ahead, for example, of mental health services, in which I've worked for a number of years as well."

To summarise, interviewees in area B demonstrated a sophisticated understanding of the interplay between individual, professional and cultural influences on their services. In terms of individuals, health staff were particularly acutely aware of how their services were strongly influenced by their current manager. In terms of professional groupings, staff understood that they remained heavily influenced by the training they had received, although they chose not to highlight the differing ideologies of the medical versus the social model of care. This mis-trust of "ideology" was again apparent when organisational culture was discussed. Staff across health and social services held broadly similar views as to what was the culture within each organisation, but were reluctant to connect intermittent cultural clashes with any potential underlying ideological differences.

Chapter 5.3.iii

Comparison of human factors

In both of the two research areas, the theme of human factors elicited a smaller amount of data during interviews than either the theme of service structure or that of policy implementation. Also, in comparing the two areas in relation to human factors, interviewees in area A had proportionately more to say on this subject than their counterparts in area B. The fact that less was said overall on this theme could be due to it being considered to be less important than other factors, or may simply reflect the nature of the interview questions. However, the significance of staff in one area having noticeably less to say on the theme cannot be so easily explained away. It seems probable that staff in area A had more to say on this topic because it was regarded as a more significant cause of conflict.

Individuals within services

Examples were given by interviewees from both areas of how single individuals had been able to exert a negative impact upon inter-organisational relations or resist change. The difference between the two research areas was that in area A these examples extended into the present, whereas in area B it was felt that such incidents were firmly in the past. Additionally, it was only staff in area B who spoke of individual current managers as actively, and successfully, promoting co-operation and collaboration across the health and social care divide.

The overall impression gained was both that relations between health and social services were more harmonious in area B and that staff in area A felt

more at the mercy of individual personalities. Whether or not these two factors are linked cannot be proven. One possibility is that people are more likely to notice the influence of individuals when things go wrong than when things are running relatively smoothly, and also that people tend to blame other people for workplace strife rather than examine underlying structures which may be the root cause of certain difficulties. Another explanation could be that the simpler organisational structures found in area B enabled closer working relationships to develop, and that the very fact of working more closely together promotes shared understandings and lessens the likelihood of conflict arising between individuals.

This second theory is, at least partially, supported by evidence that staff from the Community Learning Disability Teams in both areas reported positive inter-professional working relationships, and that these relationships had improved over time. CLDT members, due to the nature of their work, had to work collaboratively. Managers from health and social services were not bound by the same practical imperative. Nevertheless it still appeared to hold equally true at management level that working together enhanced relationships with professional counterparts across the health/social care divide. Thus managers in area B from both health and social services worked together very closely and spoke of having positive relations with their opposite numbers. By contrast, in area A, there was less evidence of managers working together closely across organisational boundaries and more anecdotes pertaining to poor inter-organisational relations.

Linking issues of personal influence and inter-personal conflict to those of organisational structure may at first glance appear to be stretching a point. However it is worth noting that, in the health service at least, organisational structures had been put in place in area B which limited the power of key individuals who would otherwise have been in gatekeeping roles. The rationale behind this was to ensure that clients received the services best able to meet their needs, rather than the managers of individual facilities being able to pick

the clients with whom they wanted to work. It was clearly accepted as human nature that staff might sometimes act in their own best interests rather than those of their clients, but by recognising this potential problem structures had been created to prevent it.

The exact balance of significance between individual personalities and organisational structures in promoting positive inter-organisational relationships is impossible to determine. However it was noticeable that a majority of interviewees in area A, where such relations were generally more fraught, believed individual personalities to be more relevant than organisational structures. By contrast, in area B most staff felt that it was a combination of these two factors that determined that state of play between health and social services. This again points to a link between structure and individual influence over services.

Professional groupings

Despite differences between the two areas in terms of beliefs concerning the role played by individual personalities, remarkably consistent views were found on the issue of the professional divide between health and social service staff. In both areas there were examples of health staff expressing concern that social services lacked the necessary skills and expertise to work effectively with the more challenging learning disabled clients. In both areas nurses and social workers in the CLDTs enjoyed working together, but yet had no desire to see their professional identities becoming any less separate.

Given the clear differences between the two research areas on many other points this sudden unity of voice was particularly interesting. Professional identity may be one of the few common denominators that link the experiences of all inter-professional teams of nurses and social workers. Professional

identity was felt to form during training, and although changes in the content of professional training could result in a cohort effect, this slow shift in professional attitudes over time was still a long way from reconciling the differences between the traditional medical and social models of care.

In addition to the effects of vocational training, there were also acknowledgements that wider social attitudes played a role in preserving the distinction between nurses and social workers. Nurses have always enjoyed a more favourable press in Britain than have social workers. This not only affects the reception which some staff may receive from clients and carers, but also impacts upon professional self-esteem. And this, in turn, will undoubtedly influence the types of individuals who opt for either professional career in the first place.

Organisational cultures

Although each organisation within the study undoubtedly had its own unique culture there were again, some noticeable similarities concerning this issue across the two study areas. In particular was the fact that most staff were more comfortable talking about "culture" rather than "ideology". The term ideology appeared to be widely viewed with suspicion, but even those staff who denied, or were unaware, that their professional attitudes, beliefs and practices added up to a particular ideological approach were sometimes able to pejoratively identify the existence of ideological commitment amongst others.

The view aired by some staff in each area that health and social services shared an ideology was uncomfortably at odds with the free acknowledgement of cultural and professional differences across services. Perhaps in this case it might have been more productive to use an alternative terminology during

interviews, given the wider socio-cultural meanings that have become attached to the term "ideology" over recent years.

Overall, the factors relating to human interaction and personality on an individual, professional and organisational level clearly had a significant impact on how services were able to collaborate. There appeared to be an important and dynamic relationship between personal influence and organisational structures, as well as more stable patterns of professional differences between parts of the workforce.

Chapter 5.4.i

Policy implementation

This third section of interview analysis will aim to examine emergent issues pertinent to the theme of local interpretation and implementation of policy. It will start by examining attitudes towards government legislation and guidance, before moving on to look at how these national policies are implemented locally. The focus will then shift to concentrate on the issue of boundaries, as demanded nationally in the distinction between health and social care, and how this division has been interpreted and actioned locally. This will lead on to an evaluation of the ways in which the health and social services in each area have sought to co-operate across such boundaries. Finally the manner in which local policy is formulated, and the constraints within which local services operate, will be examined. Issues here will include needs assessment and service planning, financial considerations and relations between the statutory and non-statutory sectors.

Central government legislation and guidance - area A

Unsurprisingly it was the more senior staff from both health and social services who were most forthcoming with detailed opinions concerning the translation of national legislation onto local practice. This was to be expected, since these are the people charged with creating local policy from national guidance.

In area A there were a noticeable number of senior staff, from both services, who gave unwitting credence to Lipsky's theories of street-level bureaucracy,

expressing the view that legislation had followed, rather than led, changes in working practice:

"I don't know whether it's anything to do with the legislation, you see. I think it's to do with the evolution of the service at that time.. ... I think it's to do with things on the ground."

"I don't think the set-up in *****, with the teams, was set up as a result of an Act. I think they were just set up because they were needed and ***** was behind. So there's been a lot of foundations there which may have been then kicked into place by legislation, but I think... I'm not sure how far the legislation pushed some of the things."

In particular, several interviewees made the point that whilst a co-operative approach to service delivery could be demanded by Whitehall it could only be created in practice by local action:

"I think the Community Care Act in a sense set a framework for co-operation. I think ultimately the co-operation isn't... you can't mandate co-operation, or it's very hard to mandate co-operation. I think it's more a question of it... it trying to consolidate a direction of travel that was probably occurring anyway."

"So there's a feeling of co-operation and I think... I think we'd be doing that regardless of the legislation. But the legislation helps."

Another commonly held belief was that legislation was simply one of many factors that had come together over time to create service change:

"I think the Act was useful in giving some common agenda, but I don't think by itself it would have necessarily led to the change. I think there's been some pressure from budgets. I think there's also been some pressure to resolve past issues like the closure of hospitals and.. and to be clear about that. That's not completely dealt with, but I think that has been a reason for working together. I think there's also issues around personalities, that.. that individuals have chosen to make things work better."

But whilst legislation was accepted in some quarters as a help in backing up service trends which had originated locally there were considerably more voices raised in criticism of how legislation, and other central government diktats, interfered with local policy initiatives. Some of these criticisms were general and sweeping:

"I think the Government have set people up to fail in the fact that there are two different agencies charged with ensuring community care takes place. I think if there was a Community Care Agency, either health or social services led, with one pot of money, then it.. co-operation, would be inbuilt from the beginning."

while others were very specific, either with regard to the government document which had caused the difficulties:

"One could argue that the ... the new requirements of the Community Care Act actually created some additional barriers that weren't there, and which workers in both agencies have had to try and get round or not as the case may be."

"Continuing care was a government ploy to get health and social services fighting as opposed to co-operating, I think."

or the way in which the legislation had been open to interpretation:

"The Community Care Act has given health the scope to opt out of a lot of things that they used to do."

The issue of legislative clarity cropped up repeatedly:

"It wasn't very clear in the.. in the Act on who should take erm.. responsibility for which kind of clients. And I think maybe it's been left up to the individual sort of areas and districts to decide for themselves whom they'll be taking main responsibilities for."

and will be dealt with in greater depth in the section on boundaries. However, in addition to a certain degree of fudging within individual documents, there also emerged an impression that the government lacked a coherent vision for learning disability services:

"The government tend to emphasize 'we should all be working together in partnership', but you do feel a lot of the legislation and a lot of the circulars and guidance actually tell you to do things that are in opposition. And so you.. you almost have to do joint working in spite of some of that."

and that this has led to a process of policy-making by default:

"I think it's driven by inquiries, the outcomes of inquiries on people with learning disability and mental health. So it's driven by mistakes."

Staff at all levels, not just those holding more senior posts, had ready opinions concerning what they would like the government to be doing on behalf of people with learning disabilities, although there was often feeling that these were little more than pipe dreams:

"With the best will in the world we're not a priority."

"I think learning disabilities has always been the Cinderella service, it's always been the blot on the landscape, it's always the bit that gets.. gets left to last. People forget about it."

As with the criticisms, however, the suggestions of what the government should be doing also ranged from demands for wholesale, radical reorganisation:

"You could go for the major thing of 'Let's have a separate.. you know, a separate ministry for learning disability and let's have separate services completely for learning disability'."

"Government legislation.. I'd like one agency, I think that would be the key thing, to have a Community Care Agency."

to desire for change in more specific areas of policy:

"If it were made sort of legal to er.. to be able to merge budgets and secondly to be able to ringfence budgets to people with learning disabilities."

"I would like the government to say who's going to take the lead on learning disabilities. I think actually, in terms of planning and

responsibilities, that would actually make life a little bit easier and it would make things more accountable."

Whilst yet others pointed to problems directly created by government structures, and which local service leaders were powerless to change:

"I'm sure it's easier for the government to pay us all money at different points, but it actually makes it difficult when you're putting proposals together and bidding for money that housing will have a different funding cycle to social services, to health, etc., etc., and.. and bringing that closer together would help."

But while many clamoured for change, others expressed concern that change might only come at a high cost to clients:

"Changing legislation at one level would feel a nice easy thing to do I think.. or at least on the face of it. I think, in reality, that just doesn't work and I think people get so preoccupied around what does it mean for me, and.. .. they just look inwards about themselves, their needs, the organisation's needs, rather than focusing outwards on the clients and what their needs are. So I think I worry that.. I would worry a great deal about doing that."

Part of the problem appeared to be a feeling that the government was somehow managing to simultaneously do too much and too little with regard to learning disabilities - too many words and too little action:

"I don't know.. sometimes the government just.. they produce lots of documents, don't they?. You gets lots of White Papers and books and they seem to come round year after year and you don't always see an awful lot changing. I think there's an awful lot of lip-service paid to learning disabilities."

The sheer volume of documentation both added weight to the perception that government lacked a coherent vision:

"My problem with all of it is there's been so much of it that's all come out within a very short space of time, all broadly saying the same thing

or variations on a theme, and how the hell it all fits together and whatever.. and.. and I.. it gets in a.. I feel everyone gets in a terrible muddle with it."

and had the unhelpful consequence of making staff pay less attention to such documents than they had done in the past:

"There are so many of these government documents and we're meant to pay attention to all of them. I'm afraid the vast majority just roll off everyone's backs, there are so many of them coming. Er.. and I remember the good old days where we.. y'know, we had one government document every other year on learning disabilities and we all pored over it and knew what was in it."

The overall impression gained was that, at least on this subject, health and social services shared a common viewpoint: that the government showed little interest in or commitment to learning disabilities, and could therefore not be relied upon to create positive change. The best that could be hoped for was that the government would remove some of the obvious barriers to co-operative working that they had inadvertently created.

In accepting that the government would not and could not solve many of the problems that had arisen from previous legislation, senior staff from both health and social services felt that it was now their responsibility to work effectively to create services for the future:

"I'm not sure that it's a question of legislation actually. I think it's a question of organisational competence and coherence rather than legislation."

although doubts were also expressed about the ability of services to grasp opportunities as they arose:

"What is still the problem is the creativity of the people, both on the ground and the managerial level, to actually take the bull by the horns and say 'Let's do this!' Anything is possible now, if you read the guidance. I mean, we can.. health can do social care, social services can

do minor community health services, we can pool budgets... .. No, in a way I don't think it is the legislation, I think it's about people just being given more confidence in some way to take risks."

Current government proposals-area A

As to current guidance and proposed legislation, views were again guarded, and typified by weary acceptance rather than any great hopes or fears:

"I mean, we have things like 'Signposts for Success' that have come out recently and I can't say that I'm terribly au fait with it erm.. er.. so I'm not up-to-date on being able to offer a decent comment on that. What worries me with it is that it doesn't look like it's really got teeth. And I sort of feel 'Well, great, but..?' And there've been wonderful advisory documents over the years that have come out with brilliant ideas but, because they've not actually ensured that resources are directed in the right direction, they've ended up being nothing more than great things to refer to."

'Signposts for Success' (DoH, 1998) received a better reception than many other documents, but nevertheless was repeatedly criticised for lacking clout. Another interviewee, who had read it, was able to give specific criticisms:

"I don't think it's got any teeth, thus far. I mean, 'Signposts for Success', for example, lovely document outlining notions of inclusion, primary care, etcetera, and then you've got sentences that say, for example, 'If you have a local GP who refuses to take somebody with a learning disability try and persuade them otherwise.' I mean.. that's nonsense."

whilst other felt that it was fine as far as it went, but that by itself it did not go far enough:

"I think probably 'Signposts for Success', in looking at inclusion and exclusion issues in health services, I think is a good first step. But I think

it should be a forerunner to.. to greater things, but whether it will do or not I don't know."

'Best value' , the banner under which the government had chosen to sell the proposed social service reforms (Cm 4169, 1998) was mentioned less often, but got a better press from those in the health service:

"I welcome the best value stuff.. I do, I think that's really good."
than from those workers in social services who would actually be affected by it:

"Does best value give us opportunities or is it just.. you know, is it just CCT (compulsory competitive tendering) by another name, extended?"

Attitudes to the recent NHS white paper 'The New NHS: Modern, Dependable' (Cm 3807, 1998) were remarkably pragmatic, given the upheaval in primary health and social care delivery which it was intended to presage. Some staff saw the potential for problems to arise:

"I think the white paper.. the NHS white paper could cause us difficulties in looking at.. there are issues around clinical governance, evidence-based practice erm.. you know, looking at outcomes a lot more and measuring them. I think where it may cause us a lot of problems is.. you know, it's not always possible to measure the effectiveness of services to people with learning disabilities. I think those will cause us some problems."

but a more common reaction to being asked about the likely effect of the proposed changes was:

"This is the one that says 'P.S. this does not apply to people with learning disabilities', so I have no idea. The impression one gets therefore is that it won't particularly affect people with learning disabilities, but I don't know. I mean, it's the kind of thing that is such an abstract statement that I just.. you know, I did flick through it, I don't think I read every word, and I just thought.. well, just wait and see really if it affects us at all or not."

And there were again comments to the effect that the government was following rather than leading the way in promoting coherent, co-operative services:

"But things have got different now anyway. People are much more willing to.. to network and to share information. It was tough at first on everybody, but it.. it has changed, even before the new White Paper."

Collaboration and co-operation in practice - area A

Whether co-operative working practices were coming about as the result of local or national factors, and regardless of the potential impact of future government interventions, interviewees in area A were generally keen to espouse the virtues of collaboration. Despite this, however, staff at all levels appeared somewhat hesitant when asked to describe improvements in co-operation between health and social services.

Senior staff from both health and social services tried their hardest to sound positive:

"I don't think services have become more seamless, but I think that we at a.. at my sort of level we try to work in partnership. I'm not sure that we always succeed, but we try."

"I think they're better integrated. I think some people might say we haven't necessarily had an improvement in services overall.. you know, money has been tight, etc, etc. But I think the integration and the working together and knowing where the boundaries are and trying to do less of the duplication of services has been better."

But sometimes even attempts to describe how co-operative working had developed over time only succeeded in unwittingly emphasizing attitudes which had doubtless contributed to earlier mistrust. This is a consultant's explanation as to why co-operation had improved:

"I think it's probably because out there now you've got more difficult clients. Before, social services could tinker around with quite easy clients and think they were doing a grand job because we had some of the more difficult ones. Now more of the.. some of the difficult ones are out in the community, so no one group has got all the expertise. And we've been working on that anyway, but I think it is probably chicken and egg: is it because there are more difficult clients out in the community therefore we have to work together, or we've decided to work together and can manage more difficult clients? I don't know."

Descriptions of inter-service relations from some hands-on staff were similarly muted:

"It sort of jumps about, I think. Sometimes it's very difficult and sometimes it's very friendly and erm.. very.. you know, in the spirit of partnership. And we do leap between all the different posts of that, I think. Erm.. it's never.. we never sit in partnership and are totally happy with that."

With some frontline staff the impression was given that co-operation existed more in theory than practice:

"There's definitely an emphasis on.. on joint working, on partnership. I mean, it's something that gets talked about a lot and I think.. I think people do try and work towards that, definitely.. yeah."

and others that local co-operation still had a way to go:

"There's a bit of a health check at the moment about how.. how our inter-agency approach is standing up to the contemporary pressures and I think that it's.. and it's really sort of saying 'Well, we've got a sort of solid foundation, but it has to move further on'."

There were also some individuals on the frontline in area A who believed that co-operative practices were being achieved. One CLDT was especially highly praised by its manager:

"This particular team is, in my view, the ultimate in seamless service. They are a fantastic team and there's no sort of internal politics between the health workers and the social services staff."

and this view was not contradicted in the slightest by other members of the team who were also interviewed. This team did seem to have developed strikingly good co-operative practices, which were not always present to the same extent in every other CLDT. However, joint teams were viewed as a way of enhancing shared vision:

"I'd like to think we were moving in the same direction, and I think that's as a result of being in the same teams."

through a shared commitment to meeting the needs of people with learning disabilities:

"I think that collaboration and teamwork is probably best done by trying to get team members to concentrate or focus on the clients and carers. And I think often that is quite a powerful technique of.. of teams working together."

Managers from both health and social services spoke of how relationships with the opposite organisation had been improved by the experience of co-operation in practice:

"I think with joint commissioning between the health authority and social services there has been more of an agenda at that purchasing level about how we can do things better, how we can work together.. which has also led to some changes on the ground."

"The joint commissioning group is multi-agency and so, as a result of that, a significant group of multi agency personnel have been working together to develop a strategy for the next five years. And that has led, I think, to an enhancement in relationships because people have had to talk to one another and be involved in that process."

Although, even in this area, there were also others who were less enthusiastic:

"In reality, you know, we've been working at it (joint commissioning) for a year now and it is long and hard and slow. And a lot of it is dependent on local personalities."

Overall, much of the talk about collaboration and co-operation in area A appeared to be just that: talk. There were undoubtedly some frontline nurses and social workers who operated in a fully collaborative manner, but this good practice had not spread to all CLDTs, nor upwards to the higher echelons of health and social service organisations. Crucially, although few staff were able to cite examples of good co-operation between services, a number were ready with examples of failure. At the time interviews took place one issue was causing particular problems:

"There are strong efforts being made now to close a hospital where there are a hundred beds, and that's a lot.. by today's standards. Erm.. and I think there's a push from the health service for that to happen. And I think, broadly, there's an agreement within social services that that should happen. It's how you do it about which there is quite a bit of debate going on at the moment."

And the actions of the health services in this regard had clearly not reached appropriate levels of consultation or co-operation. One social service manager was fuming:

"They still want to close beds before anything else has been set up. And that's where my arguments of this week have boiled over, really. Because essentially.. you know, having had the idea they then want to go ahead without actually thinking 'Where are all these people going to go?'"

And this view was shared by a (rather nervous) community nurse:

"The hospital service is changing dramatically now, but the problem is.. again, you'd have thought I'll get the sack here.. you'd have thought that if they're closing hospital services to enable people to live in the community, why on earth aren't community services here before they closed the service there?"

It was not possible to predict the outcome of this particular spat, but it served as an indication that there was still some way to go before health and social services in area A could truly be said to be working co-operatively at all levels.

Boundary issues - area A

Despite the obvious ongoing difficulties being experienced in trying to achieve effective co-operation there was still a need to define the boundaries which continued to divide service provision. Ironically, the only time that all interviewees in area A spoke in unison was when asked whether the Community Care Act had in any way made it easier to clarify the distinction between a health care need and a social care need. These responses are a typically blunt selection:

"No. I think it made it much, much, much worse, because in reality it's .. it was a false.. it's a false distinction anyway."

"No. I just think.. I mean, the more we got into it the more ludicrous it seemed."

"No. I think if you view them as a sort of.. well, everybody has both. And I think in the abstract one can say certain things are clearly health needs and some things are clearly social needs, but there's an awful lot where they are mutually entwined."

"The Community Care Act? No, I don't.. (laughs), no."

The debate concerning the distinction between health and social care was seen by interviewees from both sides of the divide as being pointless:

"I firmly believe that anything that one might consider to be health you can argue is social and vice versa."

impossible to resolve:

"I have not seen a tight definition, and if I have it's different to the agency's next door."

"From my conversations with different people throughout the country that's very locally determined. So in some places everything is social care, there is nothing that remains a health care need."
and something that would ultimately not survive:

"I think that the distinction between health and social care is going to have to go, basically, because it's meaningless."

It was also commented upon that the kind of support required by people with learning disabilities was especially difficult to define into the available categories of health and social care:

"In learning disability it's very, very difficult to divorce health care needs and social care needs, and people need a whole.. you know, integrated package of care."

"I think, particularly within learning disability, challenging behaviour is one of the hardest to define because.. you know, when is.. when is behaviour challenging within some kind of normal range and when does it go beyond that range?"

And some believed that attempts to make the definitions work were already, inevitably, leading to gaps in service provision:

"Wherever you draw a line there will always be someone who sits on that line."

"And there are clear cut gaps appearing here and there, for sure."
and highlighted the plight of two groups of clients who were feeling the effects of boundaries not designed to meet their particular needs:

"Some of those people, I think the biggest group of people, are those who have been defined as having a personality disorder, who won't respond to.. to treatment and fit very uncomfortably within the range of resources that are available in the social care sector. Erm.. equally, because they will not respond to treatment, it's.. it's very unlikely that their medics will become involved for any length of time."

"And the fact that social services won't work with people with a mild learning disability doesn't help, because there's nobody who will."

What seems to have been of concern to a number of staff is the idea that boundaries are not concerned with designating responsibilities so as to create seamless provision, but that:

"The effort to set boundaries seems to have come out of people being more aware of there being a finite set of resources."

and that such boundaries as are being drawn are created from financial considerations rather than any genuine assessment of health vis-a-vis social care needs. This has led to a division of opinion between senior managers in health:

"So the only time people have become more interested in those arbitrary distinctions is now, when the budget restraints are there. When they've come in so suddenly, things that.. you know, bopping a care assistant on the nose becomes a health care need, whereas previously, up to when the budget ran out, it was never considered a health care need."

and their colleagues in social services:

"It's very hard to say.. you know, at what level challenging behaviour becomes a health responsibility."

In the face of this some staff remained remarkably sanguine and tried to see what benefit they could in a difficult situation:

"I think now that there is a more co-operative spirit and in that sense the health and social care divide, although in most ways I don't think it's helpful, in some ways it does formally tag what is.. who's paying for what."

Whereas another, budget-holding, interviewee was furious at the idea of boundaries being drawn by calculator:

"The one that has been talked about at the moment and is being talked about by social services is basically, with regards to people who have needs around challenging behaviour, anything.. but any placement which costs above X, whatever X is.. three hundred and fifty pounds, basically nursing home rates, becomes a health responsibility, you know. And that

is then how you define health care needs. And I mean, frankly, if.. if the purchasers agree to that I think they're mugs.. you know, because I think that's just ridiculous."

The majority of those interviewed felt that attempts to delineate between social and health care were both wasteful:

"Plenty of time is being wasted in trying to decide who should provide the funding, either social services or health, and that's.. I think that's been wasteful both in terms of resources and money."

and counterproductive, since it mitigated against co-operative working practices:

"(When I first came here) continuing care had just happened, so the question of 'Do people with learning disabilities need nurses?' had just happened. And the.. the result of that was nurses all over the country grabbed onto their health role.. ... They were trying to divide health and social care and make it very pure erm.. and I think we know now that that's an impossible task."

Fortunately there was evidence that members of the Community Learning Disability Teams (CLDTs) were able to prevent semantic arguments over definitions of care from adversely affecting their working practice:

"I very rarely get involved in arguments about definition now. There's also a lot of .. goodwill, I think, so that if a case is picked up because the person has health needs that need to be actioned fairly.. fairly quickly or fairly urgently erm.. and there are social issues as well, as there are likely to be purely by the nature of people with learning disabilities and the way people live, erm.. then nurses will take on some of those roles."

And although many team members were aware of disagreements arising over boundary issues they tended to locate such problems elsewhere, either in other teams:

"I know that in some of the other teams there have been problems with erm.. individual's, I suppose, interpretation of what they're prepared to

do and what they're not prepared to do and what they regard as health or social services. And they're less sort of willing to fudge the boundaries as it were."

or higher up the managerial chain of command:

"I'm not aware of any (disputes over boundaries), but I'm sure there are. At a different level I'm sure.. I'm sure there must be."

"I think there are problems higher up into the ladder, especially where finances are involved."

Within the CLDTs there was an overall impression that, regardless of any central government diktats, nurses and social workers were taking a progressively more collaborative approach to their work:

"When I first worked with my social work colleagues there was a very strict line between health and social services. I didn't do the work then that I do now. It was primarily health. Today my work is heavily intertwined with social services."

Senior managers within social services showed an awareness that effective teamwork required the dissolution of boundaries:

"There needs to be that kind of breaking down of barriers, really. I don't.. you know, there's always going to be professional boundaries.. the only way you're going to get these teams properly functioning is to get away from a lot of that."

but from inside the teams there were indications of how tricky this could be, since alongside the willingness to co-operate across service boundaries there was also a desire to maintain professional identity:

"I know that professionals involved in both services, not just professionals but staff, do actually want to keep some divide."

The most confusing aspect of the boundary issue in area A was that, whilst CLDTs appeared to develop their own co-operative working practices regardless of any debate in the higher echelons, there was great confusion throughout both organisations as to what boundaries had actually been

formally agreed between health and social services. Somewhat worryingly there was no discernable chronological progression towards established guidelines and many staff appeared unaware of what, if any, agreements were in place.

Picking through the available evidence it appears that it took a long time for guidelines to be agreed:

"I think before we got the continuing healthcare guidelines there was a vacuum. So I think what happened.. that first of all we had the Community Care Act and the definitions of the community care legislation, and what then social services were going to pay for, before the continuing care guidelines were approved. And they took a long time to be approved locally."

This delay was partly due to the difficulty in achieving workable definitions:

"We might all have some understanding, but actually putting it in writing and then trying to balance individual needs.. so it's been difficult."

but also had an effect in terms of the eventual outcome of the debate:

"I think it.. it quite subtly shifted the boundary between health and social care in itself, because more people who might have been continuing health care came into community care arrangements because there were no other arrangements."

Even after the necessary continuing health care criteria for people with learning disabilities had been agreed, disputes over funding carried on:

"I think it was when continuing care came in initially that all sorts of difficulties.. because then you were.. you were trying to finalise who pays for what. And that was with about, I reckon, six to twelve months of absolute hell where every case would take half a day to fight out who was going to pay for what and 'I'm not paying for this'.. and it was.. it was horrendous."

although, over time, tensions eased with the emergence of a local 'case law' approach to solving funding disagreements:

"The idea is that we look back then at the funding decisions and review them.. at.. so there's actually a sort of development of case law."

"I think by virtue of a mixture of using kind of.. if you like 'case law' where we, by looking at specific people, agree principles and then work it out.. work out responsibilities.. it has begun to get better."

Despite this senior staff held widely varying views as to the effectiveness of this system. Some believed it to be working well:

"There's a clearly laid out procedure now for dealing with continuing health care eligibility cases, and clear timetables for resolving them. And we haven't had any, since we set up that procedure, that have needed to go to a higher level."

whereas others still believed that decisions were based more on pragmatic clinical consent between services:

"We know that certain people are sufficiently difficult that they cannot be managed in the community, or in the community with a high degree of specialist support, so it's been worked out like that."

But, again, hands-on staff were unconcerned with such wranglings and either saw little everyday need for such distinctions to be made:

"There's a number of definitions floating around, yes. We do have erm.. er.. I can't find anything off the top of my head, I've got it in my files somewhere."

had not noticed the introduction of guidelines:

"As far as I'm aware the working group that was put together to write that failed to produce anything.. erm.. maybe they did and I didn't see it." or felt that guidelines of this nature were meaningless without the funding from both sides to back them up:

"When it comes to the practicalities you find that resources often aren't there to provide what the document represents."

In effect, it appeared that CLDT team members had managed to establish working practices which circumvented the need for official guidelines within the teams. However, when it came to accessing services beyond the resources of the team, there were complex financial arrangements between health and social services which had taken many years to settle into established patterns. Amongst the confusion, one point which did emerge was that, by demanding formal continuing health care criteria, the government had ensured that definitions of need were determined from a health care perspective. How this may have affected inter-service relations was unclear. Some health staff appeared unsure of the facts of the matter:

"I.. I'm not sure if social services have defined what they would class as social care, but I haven't.. have no recollection of it."

but social services were, in general, unconcerned that their role was merely negatively defined and were eager to appreciate the benefits of improved relations between services:

"I think it's been better since we've had continuing health care procedures, which have meant.. you know, the health.. we've had to define health's responsibility and all co-operate together in order to get the best package of care for people."

Assessment systems and needs-led provision - area A

Although the issue of health and social care boundaries did not appear to have translated in any straightforward way from central government policy to local action, there were other areas of working practice which had felt, much more directly, the effects of national policy change. The most significant of these was the requirement upon local authorities to use a formal needs assessment schedule as the basis for accessing all social care services. The stated government intention was that this assessment would not only have a gatekeeper role, but also create a mechanism by which to determine the shape

of future services. People in need of care would no longer be expected to have their needs matched to existing services, but rather their needs would form the basis for the creation of suitable provision.

Long-serving staff members were able to recall their initial reaction to the new legislation:

"I can remember all the launch of the Community Care Act. And everyone thought this was wonderful, this was around needs assessment not service assessment and it was considered to be very positive."

but almost a decade later CLDT members did not seem to think that the change towards needs-led services had actually happened for the majority of their clients. One community nurse described the situation thus:

"The Community Care Act, on its introduction, was erm.. the idea was that it was based on assessment and that that assessment would be needs-led. But very quickly that actually changed.. although that is still.. if you like, it is still the philosophy. The working practice of it is that people who require a service in the community have to actually access existing services, if those services could accept them. Whereas the original philosophy of being needs-led meant that if a service didn't exist then one would be created and erm.. you know, that is certainly not the case."

and another complained that:

"There's an enormous amount of red tape. It seems to me that a lot of the things we do is designed to prevent people getting the services."

More alarmingly, one nurse felt that allocation of services was still not based on true levels of need, despite the implementation of uniform assessment processes:

"There are still very needy people who don't get a service and the.. and people who, because they are vociferous and can make a loud noise, get a service. That isn't needs-led, it's he who shouts the loudest or he who's got very middle class parents who are able to be vociferous, but there are still people who are very needy who do not get a service."

And this belief was backed up by a social worker who said:

"At one point we're doing an assessment and trusting people to do an assessment, but if that carer rings up the local Councilor or MP pressure comes on from above 'Let's scrap it all and give them this anyway'."

Other staff appeared to question the value of legislation which guaranteed only assessment, rather than actual services:

"Legislation seemed to erm.. to enforce assessment, but enforce no more. So the service is needs-led in a different way, and that is that the assessment of need comes first.. so it's needs-led in that respect, but in many cases you don't get much beyond the assessment."

And there were also comments to the effect that financial constraint had led to the Act being implemented only in letter rather than spirit:

"I don't think the unmet need side of the Community Care Act has been particularly well addressed. I think there was, in the very first draft of the assessments that social services developed.. I think that was the first of four we've had since then, there was an expectation that there was an area where you could indicate what services were necessary but could not be provided. I do not recall that being on the most recent update, but I would have to check that out. Whether that is to prevent social services getting into trouble if we say that there is a service that someone needs that we cannot necessarily provide, I don't know."

Alongside these wide ranging criticisms of the policy of needs-led assessment, there were also rumblings of discontent over the manner in which the assessments were conducted. The assessments initially highlighted the divide between community nurses and social workers within the CLDTs, as explained by a nurse manager:

"There was a difficulty at that time over who was going to do Extended Community Care Assessments. And, because it was a social services document, nurses felt that they shouldn't do it. So, again, that really stood in the way of seamless services and actually the person as an

individual.. doing the assessment and looking at all aspects of that person and then looking at the best service for them. Thankfully, about a year into me taking the post, I managed to persuade people that the heading on the paper really didn't matter."

Having included nurses as assessors may have improved relations within CLDTs, but it raised another potential source of inequality for service users, as one team manager pointed out:

"I've not actually done any spot checks.. trawls to see if.. you know, there is.. Extended Care Needs Assessments carried out by community nurses are significantly different from those carried out by social workers, whether there are different slants, but I suspect there might be."

Another, senior, social services manager highlighted the fact that the needs of service users and those of their carers were not always synonymous with one another:

"There's also the issue about the carer's needs and the user's needs. And we do have a care assessment form that can be used, or the carers can be assessed in their own right as.. as two different individuals requiring services."

But although core CLDT members spoke of the need for :

"Partnership with carers"

and of the approaching time bomb of elderly carers and:

".. parents who are obviously not going to be around for much longer" nobody other than on the frontline mentioned any awareness of, or commitment to meeting, carers' needs.

Team managers and senior managers in both health and social services were aware of the limitations of the current assessment process. Two issues were highlighted in particular: the extent to which assessments truly were needs-led rather than service-led, and the lack of care planning as an automatic adjunct to needs assessment. Senior staff from both services appeared to believe that the injection of an effective needs-led element into the assessment process was dependent upon the abilities of those carrying out such assessments:

"I think that where it's all got to start off from is the assessment and the vision that the worker and the person is able to develop."

and that these abilities were not always present:

"Some workers are better than others. I think workers have still got it into their heads that.. what the outcome is going to be, before they go ahead and do it. I mean, we still get referrals that say 'Request for day care', rather than requests for services.. still, after all these years. So I'd be foolish to say it was purely needs-driven."

But, in their defence, a team manager commented that very few referrals were received from people not already known to services:

"So you kind of get semi.. you know, semi needs assessment referrals made already. So we know why we're going in to look at situations, that's the.. that's the reality of it."

On the issue of care planning there appeared to be greater harmony between the hierarchies. A senior manager admitted that:

"We've put so much massive effort into the assessment and very little into the care plan at the end."

and a team manager explained how:

"What we do is we assess. We then just purchase as from what we've got available, without going through a formal care planning process."

although there was some hope on the horizon, from another team manager:

"One of the things that's lacking, and I'm sitting on a working group that's looking at it, is care planning. We have care co-ordination, we have assessment, but most people don't have an holistic care plan, and it seems to me that this is what will inform the commissioning process."

However, despite such hopes for the future, there were currently few systems in place by which needs could be recorded, collated and fed into the planning and commissioning process. Part of the problem was the nature of the assessment document itself:

"I would say we have no formal system for identifying need, we.. this.. these sorts of assessment are very much geared to identifying eligibility for existing services... .. It's not around strengths or needs, it's around.. sort of, basically, difficulties, whether people have high, medium, low or no difficulties in a particular area. And it's almost like the summary of the scores dictates at the end whether people actually qualify for limited, extensive or comprehensive service bands."

But there was also worrying evidence that social services were actively avoiding collecting information on unmet need. A social worker explained how:

"When the community care first came in there was actually a sheet for recording unmet need, but that didn't continue."

and a nurse confirmed that:

"You don't put where we can't meet needs. You will do the assessment, but you only do the assessment around what needs we can meet. That's not useful. I suppose it's politically astute, but it's not useful."

Even a senior manager commented how, before the City/County split had come into being, the level of unmet need was regarded as impossible to meet:

"The last sheet was on unmet need and that was filled out religiously for the first year, by everybody, and then ended up in a great big box of all these things of unmet need and the County said 'Stop doing it, because we don't know what we're going to do with it'. And the County was so horrified at the level of unmet need that... .. you know, it was just sad. It was too enormous and they just said 'Stop collecting it seriously', so that's what happened."

So, without a proper mechanism for collating information about unmet needs, there seemed little chance that services in the area could become needs-led in any meaningful way. Individual team managers responded to this situation with a mixture of stoical acceptance:

"We just have to do it amongst ourselves and just actually.. you know, try and make note.. reference to needs that we have identified that are

unmet. But as for mechanisms that make that happen or insist that that happens, they don't exist."

reliance on a less scientific methodology:

"It is possible, I think, to have an overview, but it's based..

unfortunately it becomes based on anecdotal information and bits that you pick up through your supervision with your staff."

and blind faith:

"I think there are pockets of practice, of service, which do appear to be coming from individual or aggregated needs.. or whether it's best guesses. I mean, I think it's still.. you know, I think there's still a role for best guesses anyway."

One senior manager, this time from the health service, blamed the lack of a current needs-led approach on past failures:

"What has tended to happen in the past is that the time lag has been so long that, by the time you've actually got resources, you've actually created a service for ten years ago which is not now needed and is now out of date."

The view from senior social service managers showed, unusually, a sharp divide between City and County. In the City new attempts were being made to embrace needs-led services:

"We do keep a log of unmet need. I can tell you.. you can ask me what my priorities are on unmet need."

But in the County there was still the impression that comments about unmet need were more spin than content:

"Once you've assessed a need you are trying to meet it, so erm.. unmet need is probably need you haven't yet assessed."

With such a lack of definite information on the subject, interviewees gave a wide cross-section of opinion when asked whether they felt that unmet need for learning disability services was rising, falling or constant. This was one of the few questions asked where responses showed no discernable difference

according to profession or level of hierarchy. Nobody actually believed that unmet need was falling, but a good number believed it to be static albeit with the proviso that:

"It's probably the same as it was, but we're becoming more aware of unmet needs."

and a roughly equal number said words to the effect that:

"I don't think we have enough information on unmet need to know whether it's going up, down or.. or staying the same. I don't think we have the information."

Amongst those who felt that levels of unmet need were rising, there were two beliefs as to why this should be the case. Firstly there was evidence that:

"Medical science is a wonderful thing, it keeps people alive for a lot longer."

which meant that more people were surviving into adulthood with multiple and profound impairments. And, secondly, improvements which had already been made to services in recent decades had created:

"Hugely increased expectations, and therefore the unmet need for services is probably rising exponentially."

And this, in turn, led some to question the nature of need itself:

"Oh I'm pretty sure there is unmet need, but I suppose then it's.. what is need? I think things.. there could always be more of things, but whether then you move into desires and wishes rather than needs."

Having ascertained that there were precious few mechanisms in place to detect, record and collate unmet needs for the purpose of service planning, it was fascinating to discover that most staff nevertheless felt able to say which services were needed locally. The three most frequently mentioned areas of deficit seemed very much in line with current national trends:

"We certainly know that there aren't the services around for people with autism."

"And again, people who present a challenge to the service, I'm not sure they get a particularly good comprehensive service."

"The other issue I think we've been looking at is the issue of people with forensic needs, but we're only just beginning."

and this had meant that:

"There's been a lot of people placed away from ***** in quite expensive services."

which then had a knock-on effect in terms of the availability of money to finance new local initiatives. Other deficits appeared to be exacerbated more by service structures than simply by lack of money:

"Mild learning disability is another interesting one. And people who straddle the boundary, not only in terms of mild learning disability but also mental health or forensic and mild learning disability. Which is a very interesting population that in many ways has different needs, certainly from people at the more severe end of the learning disability spectrum. Erm.. and the fact that social services won't work with people with a mild learning disability doesn't help, because there's nobody who will."

Deficits in services for children with learning disabilities; lack of sufficient employment opportunities; inadequate health screening and a dearth of appropriate information for parents and carers were also mentioned. Only three interviewees mentioned a need for more respite services. It seemed significant that one of the three had recently moved to the area from another part of the country:

"I was absolutely gobsmacked at the minuscule amount of respite that's available to people up here. It is.. yeah, I actually think it's quite shameful, quite frightening. Again, from past experience.. I mean, here respite services are still within a hospital base or in other people's homes which.. you know, I'm still quite.. absolutely.. you know, there's no individualised respite service in health or social services."

Coming as they did from a new member of staff, these comments threw into question the accuracy of other staff's perceptions of unmet need. If so few long-serving staff had seen fit to think about the paucity of respite care, which

in terms of community provision is a basic necessity, then perhaps beliefs about need for services were being swayed as much by what staff may have read in professional journals as by any true perception of local needs. The field of learning disabilities, as history has shown, is not immune to 'fashions'. Current national preoccupations appear to be based around challenging behaviours and autistic spectrum disorders. The fact that these were very commonly identified as unmet needs in area A may therefore reflect increased national interest in these facets of learning disability as much anything else.

The only evidence of any large-scale attempt at gathering information about service needs in the area was a local 'census' of adults with a learning disability:

"Which again was heavily flawed, but I suppose it's a start. The idea was then that that census would be repeated and then there would be.. kind of comparisons made."

But, although a social worker had been seconded full-time to this project for a year, no findings had been disseminated to staff at any level:

"So there has been work done, but it's very difficult to quite.. that work often hasn't then been turned from need to.. or expression of unmet need to then service planning. There hasn't necessarily been that transformation of the data."

Financial considerations - area A

It was to be expected, in any investigation into any area of public service, that many comments would be received about the financing of such services. Frontline workers blamed the failure to implement an effective needs-led services on lack of money:

"I think people do try where possible for things to be needs-led. But, again, you're always governed by resources, of which there just aren't any. And not just resources as in funding, but resources as in bodies.. which I suppose reflects back into funding."

And more senior staff summarised the situation as one where money, or rather the lack of money, had become a crucial driving force:

"I think that our language is needs-led. Er.. if you ask how it's really led locally for the rest it's finance-led, and within that try to make it needs-led."

For some staff the only real solution to the problems they faced was for a sizeable cash injection:

"Gosh, what could the government do? Give us some more money, give us some more resources."

but few saw a realistic chance of this being about to happen:

"Our population is increasing and the budget's not increasing. I don't notice the funding going up year on year as this client difficulty increases, I notice the funding going down on efficiency grounds at a time when I question whether we've got the same client group attending."

Part of the problem was felt to be that the types of services required by people with a learning disability were costly in comparison to those for other client groups, both in the health sector:

"I've been very struck by how expensive services are for people with learning disabilities, massively so, and the cost variance between say learning disabilities and mental health is massive."

and within social care:

"With the increases in life expectancy, our client group are the ones that are shunned. And on the face of it you would think that policy is.. that the elderly are given preference. I think in reality that's a purely pragmatic decision based around who are the cheapest to take on."

This problem was then compounded both by learning disabilities not being a politically popular or high-profile client group:

"There are too many demands on health services and I think learning disabilities are often the poor relation. And I think that's true of social services as well."

"My worry is that the client group isn't large enough to be.. isn't politically sexy, for want of a better expression. They don't win you votes."

and by learning disability services being financed, at least from the social services side, under a system designed largely to meet the care needs of the elderly:

"People with learning disabilities have got a lifetime of needs. So they're not.. they're not.. you know, with older people there's quite a turnaround as people die."

Frontline CLDT workers were unanimous in their belief that services were under-financed and this belief was shared by many, but not all, in more senior positions. One team manager felt that dwelling on such matters was simply pointless:

"I'd like to see people getting away from this notion of money, that people are constantly short of resources."

And a senior health manager made the distinction between money per se and availability of resources:

"You know that there's the funding issue, but actually the funding issue may actually be able to be resolved. The difficulty is actually 'Have we got the right sort of provision.. in the first place?'"

going on to say that:

"I get a bit critical about some workers actually, which is a bit unfortunate. Because what frustrates me is sometimes people criticise the system and criticise there isn't enough money and actually, throughout this period, I have seen money that has been underspent, systems that haven't been used, and too safe practices still happening that don't

actually allow choice and some risk-taking that would actually open up people's lives for them."

But other colleagues were less optimistic, continuing to believe that services were seriously underfunded and quoting statistics from the ill-fated local census to back up their gut instincts:

"It suggested that just around the area of residential places for example that only.. that this authority, not relating this to absolute need but relating it to comparable authorities, only funded 60% of what comparable authorities funded. So that would.. that, to me, would suggest that it is under-resourced."

And while the optimists amongst the senior teams saw this as leverage to obtain more funding in the future:

"I'm on the joint commissioning group and that's one of our targets, that.. that we've got sufficient evidence to say that it is under-funded, both in health and social service terms, for the needs of the area and, yeah, we would be arguing for a much higher investment."

the pessimists saw no realistic chance of budgets being increased:

"Any money that we find that's new money will either come from other services that have been cut, or from our own services that have been cut. I see no prospect whatsoever of any new money coming in. None."

Aside from the issue of overall levels of funding for learning disability services, there were also financial issues arising from the systems through which different aspects of learning disability services were financed:

"I'm sure it's easier for the government to pay us all money at different points, but it actually makes it difficult when you're putting proposals together and bidding for money that housing will have a different funding cycle to social services, to health, etc, etc. And.. and bringing that closer together would help."

Concern was also expressed, from both sides of the divide, about the extent of government cutbacks on local authority expenditure over recent decades and

the knock-on effect that this had had on social service budgets. A community nurse summed up the situation as one in which:

"Social services are always very restrained by their resources. I think health are as well, but you seem to feel it much stronger within social services."

And a health service manager, speaking about financial disputes between the services explained that:

"They are not just being bloody-minded, but they actually have massive budgetary cuts year on year which we have never even begun to experience. You know, we moaned and groaned like hell about 1% but.. you know, like one year they had 10% out, things that for us would just absolutely blow a hole in our services."

A CLDT team manager confirmed the bleak financial outlook for local authority services:

"Certainly all the time I've been in learning disability services, that's what.. five years, you know.. there has been year on year cuts."

and others linked this back to arguments about the structure of services, especially the lead agency issue:

"I think, personally, it makes sense that they (social services) are the lead agency. I think professionally it has difficulties because of budget constraints.. budgets are reduced year on year."

The problems arising from financial disputes between health and social services in area A, and the difficulties that this presented for establishing collaborative working practices, have been discussed elsewhere. At the time this research was conducted the situation appeared at least to be more settled than when community care legislation had first been introduced, but there remained a sense that the current situation was little more than a hiatus in an ongoing struggle:

"The principle is established that we will jointly fund these expensive packages.. until the budgets run out. In which case erm.. you know,

there'll come a point where we say `Well.. one in, one out`, but it hasn't come yet."

The solution to these financial wranglings was felt by many people to be a combination of ringfencing monies for people with learning disabilities from the wider health or social service budgets, and then pooling the budgets from both services to eliminate costly and wasteful arguments over the health/social care boundary issue:

"I think if it were made sort of legal to er.. firstly to be able to merge budgets and secondly to be able to ringfence budgets to people with learning disabilities, I think that would go a long way towards.. help in the direction."

However, for every person who felt that pooled budget could be the Holy Grail for learning disabilities:

"I think if there was a Community Care Agency, either health or social services led, with one pot of money then it.. co-operation, would be inbuilt from the beginning. While ever there are two distinct pots of money that people then, by their very nature, will protect - local authorities seek to protect their side of things, health authorities seek to protect their portions of money - that there will always be the potential for conflict. If you've got one local agency charged with ensuring community care takes place that immediately removes that."

there was another to point out the likely pitfalls:

"Pooling budgets.. you can see it sounds great, doesn't it. In practice it.. but actually then it's `We've got a pooled budget, but which proportion of this pooled budget is mine and which proportion is yours?`" " .. there are sort of fundamentals that have got to be addressed, like we charge for services, health don't."

Yet again, in finance as in so many other areas, the issue of incompatibility of service structures was having an effect on local co-operation that only government action could ameliorate.

Private and voluntary sectors - area A

No analysis of policy implementation in the community care arena could be complete without some reference to non-statutory service providers. At the time of the Community Care Act's introduction one of the core policy objectives of the then government was to introduce a purchaser/provider split in both health and social care services, with the intention that statutory services would commission services from a competing market of independent providers rather than directly providing such services themselves. From a government perspective this policy was being realised, with increasing numbers of health and social services being contracted out to the independent sector. One community nurse felt that this amounted to a virtual takeover of public services:

"I'm not sure that social services are the lead agency. I mean, I think at the moment what I'm seeing is that the private and voluntary sector are fast moving into being, certainly in residential care, becoming the lead agencies in providing care for people with learning disabilities, which I think is personally - disastrous. I think it's erm.. not only disastrous, it's unacceptable.. it's philosophically unacceptable, it opens up the options for people to profiteer on disadvantaged groups in society."

However, nearly a decade after the Act's inception there appeared to remain little in the way of wholesale ideological opposition to the private and voluntary sectors, although there were still lingering doubts about the longer term effects of this change:

"I think most people would say 'We don't care who provides the services so long as it's client-focused, client-oriented, reliable, dependable, accessible, a sense of continuity..' you know.. I think that's the things that people are more mindful of for their service users. We do use the independent sector quite a lot, whether it's.. obviously a lot in the residential services but increasingly so in day and community services. So I don't think there's an ideological opposition where people can prove

to provide a good quality service. I think it is a fear.. it is probably a genuine fear that if all directly-provided services were to go then we could see a diminution of services."

Doubts concerning the independent sector fell largely into three areas: lack of comprehensive services to meet the full range of needs of all people with learning disabilities; an insufficiently large market in the provision of services; and ineffective means by which the quality of care in this sector could be monitored.

It was clear from many interviewees that the independent sector in area A was not especially well developed. A person involved in commissioning for social services explained the local situation as one where:

"We don't have a lot of independent sector providers in this area. We seem to have more erm.. a sort of cluster of providers who do a lot of things, rather than hundreds of different providers who do lots of little things."

A senior health manager was critical of non-statutory sector providers for cherry-picking clients who were easiest to care for:

"Lots of private providers are very interested in charging quite a lot of money and having one of these nice 'happy little men and women' homes that you see on the telly when you look at programmes about de-institutionalisation. And.. you know, they're kind of fifty-five and their mum and dad didn't really get on with them or they had an illegitimate baby and were farmed off. And actually they're completely lovely .. you know, never smear faeces, never hit anyone and don't require any high levels of need. So the private providers trip over themselves to provide for those people, but of course there aren't any of those: they are all people who will wreck your house two or three times a week."

Two CLDT managers pointed out how this rejection by the independent sector of certain market areas led both to gaps in service provision:

"There are pockets which it does seem that the independent sector, or not-for-profit sector, don't want to get involved in.. that either aren't cost-effective for them, or very low return or low kudos."

and to difficulties for directly-provided statutory services trying to maintain their position in the care market:

"Provider services aren't going to be able to compete with the independent sector, where if somebody does something they're out.. you know, so we saddle ourselves with additional costs."

In terms of the independent sector which was in operation, many CLDT workers expressed concern that there were no effective systems through which the quality of care could be ensured once a placement had been made:

"We pay out a lot of money for services, but how do we monitor them? Particularly if we pay out for somebody that's placed in another area, how do we monitor that? How do we ensure that there is a good quality of care? And that is very important, because we're using outside agencies more and more often."

"How do you engage with providers to meet those services? How do you constantly review it? How d'you get out of services which you.. which you've contracted for and then find aren't delivering the goods? And that happens, from time to time."

And some were already worried that they had evidence of poor practice, but no way of tackling this:

"One of the things that we've been talking about is the number of residential homes that are springing up, but with staff that aren't experienced. Erm.. you know, some services we're paying huge, phenomenal, sums of money and then we find that actually the staff don't have any qualifications."

Managerial staff from both health and social services were concerned that the statutory authorities were not actively involving the independent sector in service planning:

"I would like to see, certainly, more of a role in joint commissioning of erm.. inviting providers in and saying.. you know, `This is our ten-year plan. And these are the people coming through our services. And we estimate that these many people will need challenging behaviour services, small provision, this.. what can you provide, private and voluntary sector?` Erm.. and seeing if we could generate some interest, which I don't think has been done to date, really."

And from within the health service there was additional concern that the perceived current inadequacies of the commissioners:

"I suspect the commissioners have a lot to answer for there in terms of.. I don't know, how creative a type of package that people.. the commissioners have asked for."

could only be exacerbated by the introduction of a commissioning role for Primary Care Groups (PCGs):

"I don't think people know how competent PCGs will be as commissioners. If you think there's about a hundred commissioners, in terms of health districts in England, you're expecting there'll probably be five hundred PCGs. So whether there's enough commissioner competence to stretch that far.."

To summarize the current state of policy implementation in area A is difficult, but probably can at best be regarded as patchy. Where government legislation had created legally binding duties, such as the right to a needs-based assessment or the obligation to purchase services in the independent sector, these had been fulfilled. What had not occurred was the implementation of greyer areas of policy, those elements which are sometimes referred to as the 'spirit' of an Act. This left area A still struggling to define the separate purposes of health and social care, and with multi-disciplinary teams whose seams remained clearly visible from all angles.

Chapter 5.4.ii

Policy implementation

Central government legislation and guidance - area B

The majority of staff at all levels in area B appeared to believe that local learning disability service developments had been largely shaped by national policy developments, and that it was this which had encouraged the development of collaborative working practices at a local level. It was health service staff who tended to be most vociferous on this point, perhaps influenced by the strong views of their Director who stated bluntly that:

"You do always need the policy context, you have to have a reason to do it other than just the services that are on the ground."

before going on to elaborate how national policy could enhance local co-operation:

"The policy context, I think, is the key thing in learning disabilities, it does focus the thinking and it does improve our engagement with individuals. Even if the personalities and the chemistry is not right between them, the policy, I think, always brings.. has to bring them together. So I would put the sort of contextual-environmental things as being more important than even the local factors. Local factors can make it work better, but they don't.. they don't actually provide enough to create the impetus for change."

Other senior health staff also backed the view that many service developments had come about as a result of central government legislation and policy guidance, rather than being instigated through local circumstance:

"I think really the initiatives have come from legislation, and it's just how we've reacted locally. So I just see us all reacting to whatever the government think up this week."

By contrast, social services' Service Manager was more circumspect about the role of legislation in promoting a shared agenda. Whilst acknowledging that the Community Care Act had:

"Helped in terms of bringing in erm.. the comprehensive assessment of people's needs and clearly identifying the social services as having a gatekeeping role in terms of the purchasing of care."

this positive aspect of the legislation was offset by other effects:

"The community care legislation brought in a lot of competitive spirits.. the purchaser/providing role, and actually wasn't particularly helpful in terms of joint working because where trusts had closed hospitals to develop community-based services, which were like social services, they had become the providers of social care. They were viewed as competitors and so a competitive environment built up."

Within the CLDT, one of the social workers expressed the belief that central government policy had encouraged co-operation between health and social services, stating simply that:

"I think the legislation has helped, with Community Care and then recently all the stuff that's been coming in about joint commissioning and joint working."

Whilst another highlighted the additional role played by specific guidance given to local learning disability services in the wake of a visit by the Social Services Inspectorate (SSI):

"My impression is that it has come from legislation, that people have been forced into looking at things in different ways. I have to say I don't know what I base that on, but it's an impression. I don't have any.. anything that I can say 'This happened in this particular way', I can only think of sort of like local things that have happened, and I suppose the major one was the hospital closure. But again, I think.. I think also the thing that's probably motivated people are the SSI inspections that pointed ways in which.. you know, people needed to work more closely

together. And then there's the central government guidance and in particular the Community Care Act, I think. And you get the feeling that, having worked in local government for such a long time I get the feeling that the push has come from outside rather than within. That's it's been responding to external pressures, rather than it being generated from within."

The significance of the closure of old, long-stay mental handicap hospitals in initiating more meaningful collaboration between health and social services was also recognised by health staff:

"We had a reason, I think, to collaborate.. a purpose and a goal, largely because the Local Authority, I think, were worried about the knock-on effects of hospital closure."

Although not everyone felt that the closure of hospital sites had had, at least in the short term, an altogether positive effect on working relations:

"I think it made things more difficult, primarily, because what it did is it.. it.. it created a lot of inequity with the people who were receiving services. So, for instance, the people who came out of the hospital were very well provided for with ringfenced budgets and it made them.. it made them.. they had a good accommodation, good staffing levels, transport, day care.. they were very, very well off for resources. Their counterparts in the local authority looked impoverished next to them. And I think that didn't help."

And a senior social services manager pointed out how some of the negative consequences of deinstitutionalisation were caused by the manner in which central government had chosen to introduce the Community Care Act:

"A lot of people jumped the gun and closed the hospitals and developed the parallel services in the year.. even six months.. even a few days.. before the legislation came in, so that they could maximise the income from Department of Health and Social Security through residential home and nursing home money. The consequence of that was

that you had these parallel services set up and they were quite intransigent."

From the above views it could be inferred that area B provided a classic example of top-down policy implementation. Certain local consequences may have departed from those envisaged by Whitehall, but services had largely been developed in line with central government proposals. However, there were also people, from both health and social services, who felt that community care legislation had not impacted dramatically on either their working practices:

"Because we've been a joint team for erm.. twelve years now, Community Care didn't overwhelm us because we were already working in that way, and doing joint assessments."

"In ***** we'd already made a start, we'd started erm.. how many years previously.. ? .. five years previously, really, doing personal service plans, which were like the.. it was really the system.. the same needs-led system that allegedly came into play with Community Care." or inter-agency co-operation:

"I think for a while it didn't have an effect because we got on with what we were doing and they got on with what they were, until somebody noticed that maybe some of what we were doing we shouldn't be, and vice versa."

And who believed that those changes which had occurred over recent years, in terms of closer working between health and social services such as joint planning and commissioning of services, had arisen due to local factors rather than just national policy developments:

"I think some of it has come around from like local reports, local inspections. I think some of it's through personalities.. I know *****'s been working very closely with social services over the last year and I think probably that's spurred it on. But maybe some influence from the government, but it doesn't get mentioned a lot and I always have the feeling that it's something more local than that."

And that there was particular pressure on learning disability services to collaborate:

"I think there's external pressures for us to.. to get on and, I think, more than that. I think because we're seen as the best example in ***** of joint working erm.. there's almost some pressure on us being guinea pigs, pushing forward joint commissioning."

It was noticeable that, regardless of which organisation they worked for, staff in frontline jobs were less likely to express clear beliefs that national, rather than local, factors were the key determinants in setting local service practice and priorities. In fact, frontline staff expressed a variety of sometimes conflicting views on this issue. By contrast, senior personnel were more likely to view central government policy as playing the major role. There are two possible explanations for this. One is that since managers are responsible for translating national policy into local practice, only they were in a position to see the full extent to which such policies had shaped local services. An alternative viewpoint, however, could be that frontline workers are correct in their belief that practices have changed little in response to policy and that managers are mistaken in their assumption that such policies are truly being implemented by street-level bureaucrats.

Current government proposals - area B

Views about the effect which past policies had had on levels of local co-operation were mixed. Health's Director of learning disability services certainly felt that the current government had taken a definite policy decision to actively encourage co-operation between services:

"The whole modernisation programme of Blair's government has meant that we have no choice now.. it's modernise or die, sort of thing."

And you have partnership, collaboration.. this is what the agenda is now for statutory agencies."

However, this did not stop others from expressing the belief that in recent years there had simply been too much 'policy' being handed down from central government. This feeling was espoused by both frontline workers:

"This is a problem that we have on the ground.. is that there is so much coming out that you don't have time to get your head round it. And.. I mean, I would say within the last year my caseload has been so big that I've hardly read a single thing."

And senior managers:

"We have got legislation blight at the moment, which is really causing a lot of problems for people at my level in the organisation, where we're expected to be involved in half a dozen discussions about where Primary Care Groups are going and how that impacts; what a HAZ (Health Action Zone) is; what should go in a HIMP (Health Improvement Programme); modernising local government.. how does this model move us towards more accountable local government; what's my role in terms of servicing, scrutiny, boards; you know.. it's just.. it's just endless at the moment."

This seemed to be linked to the belief that central government policy had changed too rapidly for services to effectively implement each new set of proposals before they were superseded by the next round of official guidance:

"And a lot of the things that are proposed erm.. never happen as well, or half happen and then go out of fashion. So part of you thinks, well what's the point?"

the constant drive for change:

"We're still reeling from other changes and er.. and maybe Labour are just moving a little bit quickly and maybe they've not thought it out. And I think they may have quashed one or two good initiatives of the past."

In addition to the general complaint that services were being deluged with an excess of policy, much of the specific criticism was reserved for the proposed NHS reforms. Both health and social service personnel were concerned that the health white paper "The New NHS: Modern, Dependable" (Cm 3807, 1998) appeared to ignore the needs of people with learning disabilities and gave little advice to those charged with managing such services as to what the future might hold. A social services manager was left in confusion:

"I don't feel I have a clear picture because each time I ask how will primary care groups affect people with a learning disability er.. people shake their heads and say "I'm sure learning disability will be left out of primary care groups" and as for other things that are being set up... I have no idea."

Whilst a health colleague similarly doubted that any clear commitment to learning disability could be discerned:

"You have to get your microscope out to.. to find anything.. anything in either, really (laughs).. that has been the hallmark of all consultation papers that have come out of the new government. Erm.. even 'Our Healthier Nation'(Cm 3852, 1998), for example, didn't really.. I think we were a single sentence in that."

Despite this, there was some degree of support from staff in both organisations for the proposed changes, in terms of both the overall direction which was being set out for the NHS:

"I do agree with the Primary Care Group system, that we've got local people making decisions about local care issues and about local care provision. I think that's perfectly right. I think that's a better idea than GP fundholders.. that was divisive. But Primary Care Groups, pooling money, pooling resources, a shared understanding about the needs of the local population, is very healthy."

and the additional guidance, specific to learning disabilities, which had been forthcoming:

"I was very pleased to see the Department of Health produce the "Once a Day" (DoH, 1999a) document which was guidance for primary care groups on the type of provision that they should be making for people with learning disabilities, exclusively."

Although there remained an unfulfilled desire on the part of some health managers to receive yet more detailed advice on how to run their services:

"I would like to see the government giving us more guidance on standards.. you know, what they'd expect our services to be like. I know some people don't like that, but I think it gives you something to aim for even if you can't achieve it straight away."

This positive approach was tempered somewhat by concerns amongst social service managers over the time which they would need to spend in order to develop effective working relationships with a whole new set of individuals within a restructured local health service:

"I have seen some very positive initiatives in relation to primary care and people with learning disabilities (sighs) .. the trouble for us is actually keeping them informed. And in a place like ***** where we've got erm.. four Primary Care Groups.. you know, it's a lot of time and energy to go out and relate to four different Primary Care Boards. So.. I'm a little anxious about the learning disability agenda disappearing."

And the fear that learning disabilities would not be a priority within the new structures was given credibility by what had already happened in practice:

"The nurses in the team, we go to the nursing group PCG meetings and so we make sure that what we're doing.. people are aware of what we're doing. But the first few times that we went people would be surprised, saying "Well, what do you do?" and.. and would have no idea about people with learning disabilities, really. And so I think it was quite worrying, if we weren't there then nobody would be even considering it."

Despite the high level of dissatisfaction with the amount of legislation and policy guidance which was forthcoming from central government, most

interviewees were able to put forward their own alternative ideas of what the government should be doing. Although one CLDT member stated simply that:

"They only make it worse with legislation."

Other colleagues were concerned to create a more seamless learning disability service:

"I think it's time it recognised that the health and social care divide doesn't exist.. it's caring for people."

Even if this entailed further radical restructuring:

"If it just made it one big department, health and social services, rather than having two separate ones."

Other issues relating to a holistic service approach to learning disabilities also appeared on people's wish-lists:

"What the government needs to do is to strengthen the legislation that will enable people with learning disabilities to have the same access to services which are non-statutory, non-specialist. So things like further education, leisure and recreation, employment."

As did several other miscellaneous, but important, suggestions concerning abuse prevention:

"We still have problems with people we think are being abused, in *****. There doesn't seem to be sufficient legislation to protect them or whatever. It's an awful area, but there are just occasionally it would be nice to have the power to do something, where with the current legislation and guidance you're not capable."

And the interface between social services and the criminal justice system:

"There's a big problem with the criminal justice system where people who have maybe got a learning difficulty commit an offence and there is no court disposal that is seen as suitable. So then they try and get psychologists to assess people as having a learning disability and instead of the.. because.. because the criminal justice system is really lacking for those people they then try and push them over to social services' learning disability services. And you end up trying to work with offenders and it's

under guardianship orders and it is very (sighs).. a difficult situation to deal with."

Both of which issues pointed up the need for collaboration and co-operation between a more diverse range of statutory services than just those found on the health/social care axis.

Collaboration and co-operation in practice - area B

Despite the diversity of views expressed as to the value of legislation in promoting co-operation between health and social services at a local level, there was evidence that effective joint working was beginning to happen in area B. Staff at all levels in both health and social services talked of how relations with the opposite organisation had improved in recent years. When asked to describe the state of current working relations, the replies were remarkably consistent. For example, these were the opinions of the most senior managers in each service:

"There's very positive, co-operative relationships between ***** community health trust and ***** social services."

"They've improved towards excellence really."

Amongst the middle managers of each service there was slightly less overt enthusiasm, but they nevertheless still imparted the sense that inter-organisational relations were largely positive:

"Generally fairly good, but with a few cautionary notes."

"I think they're very good."

Interviewer: And has that always been the case?

"It's gone through peaks and trough, I'd say."

Whilst on the frontline, amongst the nurses and social workers of the CLDT, the response to the same question was overwhelming positive:

"I think there is a good working relationship."

"As a worker I've had good experiences of working collaboratively."

Differences in enthusiasm about the state of joint working appeared to relate more closely to the hierarchical position held by the interviewee than whether they worked for health or social services. Managers were certainly aware that co-operation had been led by the ability of frontline staff to demonstrate good practice in joint working. Social services' learning disability service manager described the relationships as having:

"... moved from being positive operational relationships to being positive strategic relationships."

a change which was felt to be due to the client-centred approach adopted by frontline workers:

"We've always had good operational working on the ground, with nurses and social workers and residential workers and day care workers working together, erm.. the allegiance has been to the client group as opposed to the organisation. People aren't big on their organisation but they're big on the client group."

Similarly, health's Director of learning disability services was aware of where the weaknesses in relationships had lain:

"When I came here that clinical-operational level was very successful. The top strategic level was just the normal, boring anodyne thing it always is, i.e. pushing paper around.. meaningless. But in the middle, the sort of senior manager, director, executive level erm.. was very weak, very poor. Not much dialogue, no opportunities to meet really, nothing built into our processes to engage us together."

but was confident that this situation had now been improved.

It was from the health perspective that middle-ranking managers spoke, but their comments echoed the viewpoints of colleagues above and below them in the organisational structure. From these voices it was possible to trace a brief history of improving relationships, from:

"There used to be no relationship, really. Because this was the.. you know, health was the hospital and social services was everything else."

through:

"Although there's some.. there's not a lot of.. of examples of us working together over the past few years except at perhaps the upper echelons of the structures. In the hands-on and operational management levels there's been very little working together."

to:

"I think, perhaps a year ago, I might have described them differently, because I think we've tended to work fairly much separately other than our community team, which I think have always worked closely. But I think over the last year, with joint commissioning we're being encouraged to work more closely and we have erm.. several working groups that have joint representation. We're working together to produce some quality standards. So I think the working relationship is improving."

And there was also the suggestion of a positive cycle emerging, whereby closer working improved attitudes towards the opposite organisation, which in turn could make future co-operation easier to achieve:

"As there's been some more.. some more harmonisation of services erm.. it's given us on this side a chance to see that perhaps it wasn't quite so rosy on their side, that they were dealing with people who did present them with a range of challenges that they were to some extent dealing with quite well."

Although it could also be interpreted that the above comments about health's superior expertise in learning disability had been bolstered by certain aspects of co-operative working practice. The following example of partnership working was provided by a social service manager, who saw it as evidence of a positive collaborative approach:

"We've had a number of situations where we've brought in nurse managers from the trust to actually manage our residential units at different times, particularly challenging behaviour services where they've had the expertise to work with that particular client group."

But it is also easy to see how such a move could be interpreted as supporting the belief amongst some ex-hospital health managers that:

"We still felt that we could do better, frankly, because of the range of expertise and the range of experience we had."

Regardless of whatever mixed opinions emerged from such an introspective analysis of inter-service relations, there was some evidence of the benefits of co-operation. Closer working between health and social services was slowly being translated into improved services for people with learning disabilities. In particular, the barriers which had formerly prevented clients moving freely between services financed by health and those financed by social services were weakening. So although one CLDT member felt that:

"There's very little crossover. Local authority clients don't use our services and we don't use theirs. It's changing but it's.. it's a long way to go."

another put a more positive spin on the situation:

"I think it's getting better and I think people are more aware that there's no reason why we can't crossover and why things have to be one or the other."

Comments from higher up the organisational hierarchies painted a slightly rosier picture, with a health manager stating that:

"I think there's more joint working around clients and I think there's more discussion about clients. There are quite a number of clients who get a service from.. you know, in part from them and from us, and that would have been less likely some time ago."

And a social service colleague emphasising how they had now developed:

".. a strategic framework, a clear understanding that is one group of people with learning disabilities who have a myriad of needs, but that those needs need to be met in a co-operative way which requires a joint strategic approach. And the old separate agency approach and the ownership of clients which was there before.. you know, you'd be a

social services' client or a health service's client erm.. that needs to be out the window."

This hierarchical divergence of opinions was similar to that found concerning the influence of central government policy on local inter-organisational relations. In this case, however, there appeared to be only one plausible explanation for the variation in belief. It seems likely that frontline workers were reflecting the reality of the situation as they found it in their daily work, whereas managers were reflecting recently-introduced strategies which had yet to impact upon services.

The fact that CLDT members reported some increasing crossover of clients between health and social services indicated that moves were being made towards more seamless services, but such changes are inevitably slow. One nurse aptly summed up the improving relations as:

"I think it's uncomfortable, because it's a changing situation and that's always uncomfortable for people."

One potential reason for the hierarchical split in attitudes towards co-operative practice was the state of play at the time of interviewing in relation to joint planning. As has already been noted in the previous section on service structures, senior management in area B was working towards a merger of learning disability organisations into a unitary structure. Senior managers were largely in favour of this move, although still expressing concern on some points, and frontline staff had yet to be affected directly by the plans. However, the middle organisational tiers were both aware of what was in the pipeline and unable to greatly influence proceedings. This seemed to leave them with an uncertain future and hence led to expressions of concern about whether an organisational merger would be a positive development.

Change towards joint systems was certainly underway, and at a rapid pace. Health's Director of services spoke of:

"Moving towards the holy grail of joint commissioning."

And social services' service manager gave details of achievements to date in consolidating this direction of travel:

"The changes that are planned and are in place is about joint systems between us and the Trust. So we've got £40,000 this year to fast track the implementation of joint management systems. We've spent the last twelve months developing joint reviewing and monitoring systems around individual cases. Erm.. we have er.. or I've got on my desk to complete after our meeting, a joint training strategy."

Middle management tiers, however, were less enthusiastic about what was happening. They spoke critically of both what had happened so far:

"My experience of it is that the most.. the areas where greatest conflicts occurred has been joint planning meetings, where there needs to be some sort of consensus about.. about structures and about how they're resourced and.. and controlling, I think that's an issue."

And what might be to come in the future:

"I don't think they should pool the budgets in.. in the sense that just marry the two budgets together and say "Now it's one", because I think that would be disastrous. I think they should look at pooling.. or ringfencing resources around certain services, i.e. if we said challenging behaviour, what's the current requirement and ringfence that amount of money and.. and do it stage by stage. I think if we just join the two together and all of a sudden there's a small team of people trying to sort it out and understand it, it could really have a bad effect on relations between us and social services."

Interestingly, the CLDT team manager shared some of the scepticism of his health-based, middle management counterparts and did not see joint commissioning as a means of reducing the tensions which sometimes arose between health and social services. Although it was stressed that the CLDT had generally very harmonious relations between nurses and social workers, they were still seen as susceptible to negative influences from organisational

structures which lacked the requisite sensitivity and rapidity to respond to changing client needs:

"They're dragged into the debates when they can't find a service for one of their individuals.. a service for them. And that's sometimes because people are not being co-operative or perhaps it's because the correct service doesn't exist. So that won't go away with joint commissioning, either erm.. because there'll always be some time lag between need and service provision matching the need."

A health worker echoed the idea that joint commissioning and pooled budgets would not resolve any of the difficulties experienced in joint working, arguing that such a change would merely alter the basis upon which conflict arose:

"The arguments won't go away, I'm afraid they won't (laughs). The er.. there will be differences in opinion about the levels of support some people need and there will have to be.. the difference will be that we'll all be pulling from the same pot of money, rather than from different pots." "So the argument would be how it's used, rather than.. than take it from them or give something away. It's.. it's operating within rather than pulling something from externally."

Perhaps it was the uncertainty of their own future positions which lead the middle organisational tiers to look on the black side and point out how little benefit might be derived from changing the status quo. Health's business manager summed up the situation as follows:

"I think we need to sort out the joint commissioning approach. Whether it.. you know, it's almost that the need to agree what's going to happen overrides what's going to happen. It's like we need to say we are going to do this, that's the need now.. you know. What we're going to do becomes less important, I think, as time moves on."

In other words, since it had been agreed that joint commissioning was going ahead it was best to concentrate in making it happen under whatever formula because the hiatus between policy and implementation was simply not helpful to anyone.

Boundary issues - area B

Issues of whether and how to distinguish between health care needs and social care needs lie at the heart of inter-organisational relationships in the provision of health and social care services to adults with learning disabilities. The legislative issue which provoked the most unified response from interviewees was whether or not the Community Care Act had been effective in its objective of creating a clear demarcation between health care needs and social care needs. The overwhelming opinion of workers from both health and social services, frontline staff and managers, was that the Act had not been successful in this respect. The following is a cross-section of replies in response to the question of whether the Community Care Act had helped to clarify health and social care roles and the boundaries between them:

"I'm not sure that it did, no."

"Did that Act? .. no.. no, it didn't.. no."

"Not at all. Not in any shape or form."

"No. Never."

"I wouldn't say so, no. Not the way we.. we've implemented things."

Responses to this question tended to be briefer and more direct than answers given at any other point in the interview, as if it was naive to suggest that the Act had, or could have, defined such a boundary. The few who did choose to respond at slightly greater length shared the same basic opinion as their colleagues, but also took the opportunity to emphasise the manner in which this lack of clarity had served to create geographical diversity in the interpretation of this legislation:

"It certainly said health providers should provide health services and social services should provide social care, but I don't think it defined it, er.. that's why there are so many different definitions now of what health care might be."

"Well, no, it didn't clarify those roles. And if I just look at er.. neighbouring authorities around here, you see that.. the definitions of health care needs and social care needs are completely different in all the authorities."

Some individuals went even further, claiming that it simply was not possible to delineate meaningfully between health care and social care needs:

"I've had numerous discussions with various agencies and various disciplines about what's health and what's social care and where's the dividing line, and it's impossible. There's a continuum that goes through and you can never, ever separate and say 'That bit's health'."

But, regardless of opinion on this matter, the practicality of implementing the government's community care legislation meant that a boundary had to be drawn somewhere to distinguish, however ineptly or imperfectly, between health and social care.

The Community Care Act was not the only piece of policy which emanated from central government that had sought to define a boundary between health and social care needs, but there was scant evidence that subsequent guidance in this area had been any better received than the original legislation. The CLDT team manager was particularly scathing about the government's continuing health care guidance, which had sought to help clarify the boundary issue:

"I don't think there's been any continuing care guidance. I think everything we've had has been so vague as to be totally useless. I have had several continuing care documents across my desk over the years and none of them told me when a person should be the health's responsibility."

And health colleagues also expressed frustration at the current government position, in terms of both its inability to deliver the services needed by people with learning disability:

"I think it's time it recognised that the health and social care divide doesn't exist, it's caring for people. And that may be caring for.. in a holistic way, that it's caring for that person so that they have a certain quality of life, whether that's their physical health or mental health, social wellbeing or whatever."

and its failure to provide guidance which actually helped to make implementation more straightforward:

"I'd like to see something that was either very flexible, which I don't think we've got, or something that's completely sewn up.. you know, so it's bang to rights and that's it."

Of all the staff in area B it was only health's Director of services who expressed the belief that government policy of any kind had been useful in clarifying the boundaries, and there was a clear awareness of how unusual a view this was:

"There are two quite important circulars on health care and social care erm.. both of which begin to.. the mere fact that they are in existence, I think, indicates that there is some distinction to be drawn. I believe there is a distinction as well, I am one of the few people in captivity that believes that you can draw a definitional difference between the two."

Opinions held by individuals are created by a multiplicity of personal influences and experiences, but in this case it is noteworthy that attempts to put policy into practice with regard to defining these boundaries all appeared to have taken a definition of health care needs, rather than social care needs, as their starting point. The Director emphasised this aspect of inter-agency negotiations at several points, describing how:

"It was critical to get the health care definition nailed down and then as it were.. with regard to that definition the social care definition was made much easier."

and later repeating that:

"I think we have all the concepts clear, of why we're doing what we're doing. I think key to it.. I keep coming back to it, the key to it was

defining health care and being clear in our own minds that we understood what our business was, and the limitations on that."

Other health managers talked of how such boundary definitions might soon translate into alterations in service delivery:

"There's an agreement that some of the sort of social care.. some of the day centres that we run that don't have a particular focus, would be in future run by social services."

But although the social service manager also expounded upon how health and social services were seeking to correct some of their past confusions as to who should run which type of provision:

"If I was to describe a services that had people with profound and multiple disabilities who required intensive nursing care that sounds like something that a Health Trust should be running. In fact we've got three large units that deliver those services within social services. If I was to describe to you an employment service that's helping people develop skills in print-making that sounds like something social services might be running, but in fact the Community Health Trust runs that. So we got into each other's business operationally, because we didn't work strategically. The last five years, and in particular the last three years, we've worked a lot more strategically together."

no-one from either organisation was able to offer a free-standing definition of what might constitute a social care need. This meant that social care became defined, by default, as being any need that was not related to health care.

Whatever the philosophical or theoretical underpinnings of the attempts to define this crucial boundary, and irrespective of the fact that many care professionals of all hues regarded such a distinction as meaningless, there nevertheless remained a need to create workable definitions of health care and social care to use in daily practice. This necessity was largely driven by financial considerations, as a social worker explained:

"I think budgets, the fact that budgets were finite, made us look at what we should be paying for and what other people should be paying for." but had originated in the community care legislation's attempts to ensure that health and social care services were separately identified and financed:

"Prior to the Community Care Act, I don't think.. I don't remember thinking about it in that way, it was a need and you looked for wherever you could get it, but it wasn't so much apparent who was paying or who should be paying."

The need for financial lines to be drawn around need had led to the continuation of a system of boundaries which trapped clients, seemingly at random, under the auspices of either health or social services financial provision. This situation was acknowledged by nurses:

"Local authority clients don't use our services and we don't use theirs." and by social workers:

"There are some users who.. who live their lives totally within health service provision or totally within social services provision, depending on their point of access into services.. and there are only a few that move between services."

There was a clear desire to change this, both on the part of frontline workers:

"It would be much simpler if anybody.. with doing anybody's assessment that everything could be as accessible to everybody, rather than it being more accessible to one person because they have health funding or more accessible to another person because they have social services funding. That would make things much easier."

and on the part of the senior managers who were seeking the introduction of pooled budgets to eradicate the problem:

"On the ground what I would like to see very quickly, though, is the removal of the boundaries between health and social care provision where funding is required to follow someone into a service. I see no reason why, if we totally remove the boundaries, a person with learning disabilities shouldn't be able to access any service whoever manages it."

However, until the effects of pooled budgets and joint planning systems shifted the paradigm elsewhere, there had developed a working understanding of the split between health and social services. Beliefs about how and where this line had been drawn, as with other aspects of implementation, divided along hierarchical rather than organisational lines. When asked whether local guidelines were in use which defined the health/social care boundary, both nurses and social workers replied in the negative:

"No. Erm.. I don't think so."

"No we don't.. no. I think it's the grey areas isn't it, it's the either/or areas that.. that pose a problem, because some are one or the other aren't they. But no, we don't have any actual set guidelines about how we define which."

And although they proffered a hackneyed example of occasional disagreement which might arise over this issue:

".. .. perhaps when they're having a bath for instance.. as to whether that's health or social."

they did not believe that such arguments arose between senior managers, and gave an example of a working party on meeting the needs of the elderly learning disabled population:

"Health was saying 'Well, those are obviously our bits' and social services were saying 'Those are obviously our bits' and they were able to do that perfectly well without disagreeing about who was responsible for what. So at that level it seems to be fairly clear as to whose is what bit."

By contrast their team manager, whose position in the organisational structure meant that he acted as a buffer between frontline assessment and managerial strategic planning, was aware of the existence of such guidelines but did not feel that they helped to decide whether a need was health or social:

"We've got all sorts of protocols, but none of them help you make any decisions."

and went on to say that the debate on this matter was in any case becoming redundant:

"If we're moving towards a system of joint commissioning, some of this discussion is.. seems a bit erm.. temporary, really, because.. shifting money from one budget to another if we have one budget.. what's the point?"

It was in the uppermost echelons of each organisation that fewest doubts were expressed about the existence and efficacy of the boundary between health and social care. Even here, however, there was a marked difference of tone, with health emphasising how they had defined their responsibilities:

"We have a joint strategy now, a written joint strategy. And it's.. some elements of it are enshrined within that, some.. for example, part of.. we've defined health care a number of different ways, if that's where you're leading to. But one of the.. one of the aspects is really to agree demarcation on cohorts, if you like, erm.. clinical cohorts. So we, as health providers, have taken the lead on three main areas. We've taken the lead on challenging behaviour/mental health dual diagnosis issues; special care, by which we mean people with profound, multiple handicaps, complex needs and so on; and autism."

While social services stressed the expediency with which they had chosen to tackle this aspect of joint working:

"We have taken a fairly pragmatic approach. Erm.. a lot of.. we've actually said there's no point arguing about health and social care money if there isn't any more money to chase. So if the health care pot is ringfenced and the social care pot is ringfenced, and it's not going to get bigger, there's no point social services saying 'Hey, this is a health care need. We want you to find the money' if they can't find the money. Similarly there's no point in health saying 'This is a social care bath.. it shouldn't be done by a nurse, it should be done by a home help'. So we tended to come to an agreement about identifying the problems and working to resolve them without fighting too much over the money."

It was not entirely clear as to whether the strategic agreements concerning the health/social care boundary made by senior managers had simply not yet filtered down to frontline staff, or if the boundary had been carefully crafted so as to appear seamless. The relative lack of debate over this issue amongst members of the CLDT did, however, seem to contribute to the harmonious working relationships at this level and the constant emphasis on putting clients first. A long-serving nurse put it thus:

" You're looking after a person, not a set of symptoms. So you can't subdivide that person into symptoms that some belong there and some belong here or you forget the person in the middle and that's.. that's contrary to our philosophy, which is holistic care."

Assessment systems and needs-led provision - area B

Several references have already been made to the important role played by individual client assessments in area B. Staff from both organisations and at all hierarchical levels exhibited an excellent understanding of how this system worked to both ensure quality standards and to create services which responded to the changing needs of the local learning disabled population. There were two elements to this process: the assessment of need and creation of individual care plans was conducted by nurses and social workers in the CLDT; and the outcome of these care plans was then reviewed and monitored by the C.O.R.E. team, which also collated information on current unmet need and future needs to feed through into the strategic planning process.

There were, perhaps inevitably, some criticisms of the system. Nurses and social workers whose remit was to undertake individual assessments of need were sometimes unconvinced that the exercise was completely needs-led.

There was certainly evidence of regular changes of emphasis in how assessments should be conducted, as one social worker explained:

"We started off prior to Community Care Act with a system that was.. we called it a personal service plan, that was needs-led. We then sort of like slipped into a more service-led, I think.. I think that was partly because we didn't have a way of measuring how needs-led services were being delivered. Erm.. then came Community Care, and we were back into needs-led. And then we were into don't.. don't identify anything we can't provide because we will be in judicial review, so we went through a little phase of that. The instructions changed so many times I cannot tell you."

The learning disability service manager also recalled problems in the development of a needs-led system, but seemed confident that the current approach enabled the effective collation of information on needs:

"Part of the problem within the Community Care legislation was that, before the Oxford ruling, we were very scared to identify that somebody had got a need we couldn't meet. And it was amazing how many assessments actually came out saying that what people needed was what we'd got. We got into a dialogue with families and er.. following the Oxford ruling, where we could actually.. which stated that we could actually say that there was a need but we couldn't meet it.. yet, but we were looking at how we could meet it."

Perhaps as a result of this early failure to conduct truly needs-led assessments, there remained a worry in some quarters that the current system still failed in this objective. This was a particular concern if the person being assessed had little useful speech. A nurse described how:

"I would be going out and doing assessments on people and talking to the staff and things and sort of.. if the person's communication skills weren't very.. and they couldn't say what they wanted for themselves.. you know, talking to staff and saying 'What do you think this person needs?' and they're like 'Oh, well.. yes, they need to go to the day centre

four days a week' and that's.. that's it. And you're just like 'But no, if they could really do whatever they really wanted, what do you think?'. 'Well, no, they like going to the day centre' (laughs) and people can't get away from just seeing things as what they have."

Although other colleagues were equally convinced that every conceivable effort was being made to listen to clients:

"We set up structures that enable people to be represented well.. in the best possible way. We could do that through advocacy.. self advocacy, citizen advocacy.. those are the structures, so that people have some sort of opportunity of influencing their own care. And therefore we're focused on what they want and what we perceive as their needs and what they tell us their needs are. And I think our care planning is pretty well up to speed on that."

Some CLDT members also felt that the need to ration scarce resources had an influence on assessment outcomes:

"Setting up your care package you go for the best that you can get, at the same time with a.. with a thought in your mind that you've got someone else on your caseload who's going to need such-and-such, so you don't want to take it all. You've got to have some sort of awareness that you can't ask for the.. for a vast amount for one person, because you know that then the next person who comes along is going to suffer."

Although it was possible to interpret this as a positive aspect of the system, in that frontline staff's awareness of resource limitations could help maintain an equitable, needs-led, distribution of those resources:

"We have to start trying to ration what we've got so that everybody gets something and it's fair. That's not easy, but we can't allow ourselves to be persuaded by those most outspoken people who get the lion's share."

However, despite some imperfections, the system appeared to be robust. The CLDT team manager, who had been fiercely critical of some other aspects of local policy and practice, praised this element of work:

"The most important thing we're doing is setting people writing care plans so that we know what we're doing and why we're doing it. And people will have to find.. are going have.. after some time we're going to check up to make sure they've done what we've asked them to do. I think it's as simple as that."

and described how the system made it possible to:

".. to collate information about different groups of people. So information is collected from the assessments we do with those people to try and decide how services should be in the future."

The two most senior managers from health and social services felt confident that:

"The needs assessments will influence that sort of decision-making.. that sort of strategy, there's no doubt about it."

and that:

"As a result of the assessment we look at what can happen now in somebody's life, what change to their care plan could be made which would immediately improve things. And then we have a view about what needs to happen over twelve months. And then what needs to happen longer-term.. strategically, which might be about de-commissioning and re-commissioning of services."

CLDT members again expressed some reservations about the system in terms of its clarity:

"I don't think the assessments have been clear enough in what they've in what they ble to actually say 'Right, well we need to develop this or that'."

and the length of time taken between identifying unmet needs and services being developed to meet those needs:

"Changes seem to come very slowly and they're talked about, and they're talked about and you think.. well, I'll believe it when I see it."

"I think there's always a problem with the time lag which is going on with all the groups. Sometimes we've identified needs but it might be two years before.. of me jumping round so that the services are better organised to meet the needs we've identified."

But despite this there was compelling evidence of successful attempts to assess the requirements of certain groups within the learning disabled population and, vitally, to feed this information into the planning process. Hence a nurse spoke of how:

"We've assessed all the people over the age of sixty-five for instance, and I've collated all the assessments together and we've gone through those and erm.. there are things in there that are highlighted that people need: more leisure activities for instance; shorter days at day services; more luncheon group type activities which are leisure and social based rather than work-oriented, for instance. Erm.. so we've done that and we've presented that to the managers and it's now been left with them to further develop it."

And the service manager was actively aware of these needs:

"We've identified a necessity for a new 22-person day service for frail elderly people and the necessity for a service for people with Down's syndrome and early onset dementia. Up to this year we were having six people a year being referred to us.. or being identified as having early onset dementia and Downs, so far this year.. we've had more than that already. So we don't know whether that's a blip or whether this is a new trend, and we've been successful in getting Department of Health funding for specific research into that and research into identifying the types of services that we need to respond."

Given that the current system of assessment, care planning and review had only been in place for less than a year at the time interviews were being conducted it was perhaps too early to state categorically that services in area B

were truly needs-led. However, information about client need was being generated in a systematic way and there were clear mechanisms for feeding this knowledge into the planning of future services. Given that managers held out little or no hope of an increase in funding:

"I don't believe there is any potential for growth in our services. I think there is potential for reconfiguration and cycles of de-commissioning and re-commissioning."

the success or otherwise of this system in reflecting the changing needs of the learning disabled population will impact directly on those people's quality of life.

Financial considerations - area B

As with any public sector organisations, health and social services in area B were aware of the financial constraints under which they had to operate. Managers from the health service were blunt in their assessment of the levels of funding likely in the future:

"I think it's likely to go down, if anything."

"Generally maybe there's a bit of a downward trend."

Social services managers appeared similarly realistic about their financial position and knew how it compared to the position of local authorities across the country:

"The amount of money we're spending in ***** is bang on the average national proportion of spend."

"It's £33 per head within the SSA (standard spending assessment) and that is the national average, and we're bang on it. So.. we've got the right spend or benchmarking."

But despite pointing out the particular challenges which their services were likely to face in the future due to:

"... the demographics in *****, with a high.. very high young population and a very high level of disability."

they were also clear that it was up to themselves as managers to provide services within existing financial constraints:

"There's not going to be a major increase in the SSA, there are no other knights in shining armour in the wings ready to charge in and save us, so we're going to have to cut the services to suit the cloth, really. And that means that services are going to have to be more focused, they're going to have to be clear about who their client group is, what they're delivering, erm.. some areas that we're delivering now will disappear and some new areas will come."

Such financial restrictions were not seen as a reason to behave any less co-operatively. In fact, if anything, shared financial difficulties appeared to have helped foster a collaborative approach to meeting future needs:

"Now we've got to the point where there's no more new money for social care and there's no more new money for health care. We're actually working jointly in trying to identify very clearly how much social care is needed, how much health care is needed and how we can use the single pot of money erm.. to address that, knowing what the priorities are."

CLDT members tended not to comment a great deal on financial matters and although one worker from the health side believed that budgets for learning disability services were suffering in comparison to those in mental health:

"I look at things and complain bitterly about their (mental health services') continuing large overspend, and yet they don't seem to have to work within the same sort of rigour as we do, erm.. and there seems to be very little sanction on them for not doing it, whereas people are very keen that we operate within our budgets."

this concern about relative favouritism between client groups was not necessarily shared by other members of the team, such as this social worker:

"I'm aware that there's pressure but I don't know that the pressure's significantly disadvantaging people with learning disabilities any more than anybody else."

In fact the only major financial gripe, repeated by staff at all levels on the social services side, was that budgets were not effectively ringfenced. A social worker explained how:

"Budgets change throughout the financial year, so that at one point in time you can be told you've got this amount of money to spend and the next week, for example, they could be told they've got a completely different amount."

More senior staff echoed these concerns, but were also hopeful that the current problem could be ameliorated:

"The fact that learning disabilities has supported.. or provided financial relief for other services erm.. on a year-on-year basis will have to be acknowledged somewhere along the line and we may well lose some of our budget before we move into the pooled situation."

"I think one of the things we want from joint commissioning is the ability to have ringfenced budgets, so that means when we go in we know how much is in the pot."

Overall, interviewees in area B were remarkably sanguine about any financial difficulties which they faced. This attitude is perhaps best summed up by the following quote, which combines the desire to improve services with an acceptance that money cannot provide the whole solution:

"I'd like to see things better planned.. services better planned and organised, but a lot of that is dictated by resources. Some of it.. I mean.. finances, I know, do get used as an excuse. And people put things off until such-and-such happens or such-and-such a person arrives or we've got this money, but I think that.. yeah, things could be better organised and planned."

Private and voluntary sectors - area B

Up to this point it would appear that area B had been reasonably successful in fulfilling the policy objectives of the Community Care Act and subsequent related legislation and guidance. Health and social services had defined their respective responsibilities and developed a co-operative framework within which to assess the individual and population needs of people with learning disabilities. However, a key objective of the original legislation had also been to encourage the purchase of health and social care services from non-statutory providers in either the private or voluntary sectors. In this respect, area B had been less assiduous in its implementation of government objectives.

Health appeared to have a reasonable number of services tendered out to other providers:

"We have management agreements.. contracts with seven other organisations at least, as well as the local authority."

And to find these relationships straightforward:

"They can be commissioned to provide something for an amount of money and that's quite simplistic and probably easier than direct provision."

Although some health staff felt that this was significantly changing statutory organisations:

"There are so many providers now within our services, we have lots of independent sector providers and charitable providers and we're working increasingly together, that the local authority and the health authority have become smaller."

The view from the business manager was that contracts were currently limited to certain specific areas:

"We have a lot of arrangements with housing associations in terms of they provide the accommodation, nursing home and residential home. And we also have an arrangement with an organisation called Support Works, who've now merged with a housing association anyway. and

they used to run some day services for us as well as residential accommodation. Erm.. and that's about it."

The relationship between social services and the various elements of the private and voluntary sectors was more limited, and was described by the service manager as a situation where:

"The for-profit agencies have actually kept their noses out. The not-for-profit agencies have been very active, in terms of touting for business and trying to get involved in service developments. The voluntary sector itself, the pure voluntary sector, is very small in terms of the amount of provision that it has, but it's very active in terms of the sort of agitprop.. er.. Mencap, People First, individual advocacy groups, but they're not major players in terms of service provision."

There was an active independent sector in the provision of residential care, but this had not spread into other service areas:

"At the moment the bulk.. the big day service providers are social services and health and there are one or two smaller things on the edge."

Under the provisions of community care legislation social services were obliged to spend a certain proportion of their budget on purchasing services from other providers, and this duty was fulfilled:

"We do spend two and a half million pounds a year in the independent sector, through the community care budget."

but without actively encouraging independent providers:

"Two and a half million spent in the independent sector out of an overall social services budget of ten million.. 25%.. that's not bad, but it's still not enough to attract major new development in terms of the voluntary sector."

Which was very much in line with the local political environment:

"I think the reason for that is the ***** political culture, which is old Labour.. very much about being the biggest employer in the area, seeing

that employment role as very important to the people of ***** and to job security and the like, not wanting to get into tendering of services."

To summarise, area B had implemented the core elements of community care legislation whilst maintaining a service which strongly reflected local circumstance. Those aspects of central government legislation which were not seen as sitting easily with the local agenda had been adopted with less enthusiasm than those elements which championed the needs and wishes of the local population. But, essentially, central government policy had been implemented in a sensitive manner.

Chapter 5.4.iii

Comparison of policy implementation

In comparing how the two study areas had sought to implement national government policies the most striking feature was the inconsistency of difference: some views and actions were very similar between areas A and B, while other varied wildly. The different organisational structures in place in each area have already been described, this section seeks to go further and demonstrate how these structural variations have resulted in differing implementations of what are ostensibly the same policies.

Central government legislation and guidance

Some of the criticisms levelled at central government policies from staff in both areas shared the same themes. In particular there was a feeling that a recent escalation in the volume of official policy guidelines for learning disability services had largely failed to provide the advice desired by those on the frontline. The proliferation of policy had not resulted in any increase in clarity of those policies, and may have contributed to a sense of confusion amongst workers who simply did not have enough time to read the documents which were supposed to be providing a framework for their practice. The introduction of Primary Care Groups, as a precursor to Primary Care Trusts, was therefore regarded with widespread suspicion and a fear that learning disabilities were likely to be further sidelined within such a system.

However, although the above general attitudes to current government policy were shared, the two areas showed divergent attitudes towards many other aspects of policy. Of particular note were the views held by senior managers

across health and social services in each area. In general, area A's managers were more critical of government policy than those in area B, who were able to point out both positive and negative aspects of policy. More specifically, managers in area A tended to believe that legislation had followed, rather than led, changes in local practice, whilst area B's managers believed that changes to their services had been made in response to government policy rather than pre-empting it.

One possible explanation for this is the different timetables of hospital closure. Area A had succeeded in closing its old, Victorian long-stay mental handicap hospital long before the introduction of the Community Care Act and as a result perhaps felt that it was ahead of the game in developing community-based services, notwithstanding the fact that a more modern hospital with one hundred inpatient beds remained and continued to serve as the base for health's learning disability services. In contrast area B's old long-stay hospital had only been finally shut down in 1992, which meant that ex-patients were still being moved into community provision as the Community Care Act came into effect. This meant that as soon as area B's health services began operating in the community they were exhorted by government to co-operate with their local social services department. The earlier development of community-based health services in area A meant that they had not, from the outset, been compelled to collaborate. Area A had perhaps therefore found it harder to foster good relationships with social services at a later stage of service development. This difficulty had then been compounded by the reorganisation of local government and the creation of two separate local authorities from the previous single structure.

Frontline staff in both areas had relatively little to say about implementing government policy. This was unsurprising, since although it was they who were the ultimate 'street-level bureaucrats' of the implementation process, their direct experience was of implementing policy as mediated by local management.

Collaboration and co-operation in practice

The overall impression gained from conducting the research interviews was that area B had succeeded in developing effective co-operation between health and social services to a greater extent than was evident in area A. Staff at all levels, and from both health and social services, in area B spoke positively about the gradual improvements in inter-service relations which they had witnessed, while their counterparts in area A were much more circumspect about the progress being made there. These perceptions were clearly based on experience, with area A interviewees offering few examples of co-operation in practice, over and above the existence of joint Community Learning Disability Teams, and a very clear example of how the health service was failing to act co-operatively in its plans to reduce in-patient facilities. However, this overarching difference masked some notable hierarchical and organisational similarities in attitude towards collaboration.

In both areas it was staff at the 'top' and 'bottom' of the health and social service hierarchies who were most likely to champion the co-operative cause. Staff in CLDTs in both areas did work together effectively, although health/social relations in some of the CLDTs in area A appeared to have suffered from the complex supervisory and referrals systems, as discussed in the previous section on organisation structures. Senior staff across both health and social services shared a common language of co-operation, although area B was clearly at a more advanced stage of putting this theory into practice. It was also encouraging that staff from both areas reported that their experiences of trying to work co-operatively had improved relations between organisations, giving hope that a positive cycle of joint working could gain momentum.

The more negative voices all tended to come from middle-ranking staff, who were quicker than colleagues above or below themselves in their

organisational hierarchies to point out failures in existing co-operative practice or fears over proposed collaborative ventures. These were staff who were neither in completely hands-on frontline jobs, where local policy was a matter for the tiers above, nor were yet powerful enough to be major players in determining the direction taken by local services. Moreover, these were perhaps the people who had most to lose and least to gain from joint commissioning and pooled budgets, since their positions could either disappear or diminish in importance as moves were potentially made towards organisational merger.

Boundary issues

The fact that health and social care professionals believe the Community Care Act to have not helped clarify the distinction between a health care need and a social care need is the only completely unequivocal finding of this research. Beyond this one nugget of certainty, however, there were vast aspects of uncertainty as to whether and how any boundary could or should be drawn between health and social care needs.

Comments on the boundary issue showed some likenesses across the two areas, with an awareness that different definitions of health and social care were possible, a belief on the part of some individuals that trying to make such a distinction was pointless, and an acceptance that in practice boundaries had to be drawn for financial - if no other - reasons.

The actuality of defining a boundary between health and social care in each area proved to be quite different. Although some frontline staff in both areas expressed the belief that such boundaries had only become of relevance as budgets shrank, and hence the distinctions made were based on financial

considerations, comments from more senior staff in each area shed more light on definitional variation.

Area A's senior health team had clearly made several attempts at drafting documents which defined health needs and could be used as the basis for determining access to health care services for people with learning disabilities. These attempts appeared to have been largely unsuccessful and as a result a system of 'case law' had developed in the wake of numerous wranglings over whether health or social services should pay for individual packages of care. Area B also appeared to have largely defined the boundary from the health perspective, and to greater effect. In this case no attempt had been made to define health needs per se, but instead health managers had clearly stated which types of client they regarded as being their responsibility to provide for. This obviated the requirement to determine whether the needs of an individual were health care needs or social care needs: every individual has needs which fall into both categories, but it had nevertheless proved possible for a broad agreement to be reached between health and social services.

Staff on the frontline in both areas showed a healthy disregard for the intricacies of boundary definition, preferring to look simply at need and leave it to others to argue over who should pay for the services needed. The boundaries between health and social care were not emphasised by team practice in either area, and this would certainly have helped achieve the aim of 'seamless' services as seen from a client perspective.

Assessment systems and needs-led provision

It is at this point that the analysis shifts from an examination of the attitudes and beliefs surrounding implementation to an appraisal of actual practice. It is

also at this point that the disparity between the two areas becomes most apparent.

In line with the statutory requirements of the Community Care Act, social services in each area had introduced standardised systems for assessing the care needs of individual clients, and these assessments were then used as the basis for determining which services would be provided in order to meet those needs. In area A this was pretty much as far as it went. This meant that although assessments were theoretically needs-led, in practice needs had to be met through existing service provision. More worryingly in the long term was the fact that unmet need for services was not recorded. It remained unclear on exactly what basis future services were planned, but the system could definitely not be said to be needs-led in any meaningful way. There were also concerns in area A that care plans were not updated regularly and that once a person was in receipt of services, particularly services provided by the independent sector, there was no system of needs review or quality assurance.

The situation in area B was much closer to the spirit of community care legislation. There was a clear system of needs assessment and care planning, with related quality controls, and a systematic collection of information on needs which were as yet unmet. This meant that future services could be planned on the basis of sound knowledge about the needs of the local learning disabled population. At the time interviews were conducted the full system of assessment and review which area B had adopted was still in its infancy, and some staff remained anxious about the time lag between identifying needs and the creation of new services, but there was clear evidence that needs were feeding through into the planning process and little reason to believe that this dynamic juggling of resources would not continue in the future.

Financial considerations

Some staff from both areas felt that their services were finance-led more than they were needs-led and a concern with financial resources was generally apparent. In both areas there was an awareness that the needs of the learning disabled population were increasing, due to such factors as higher life expectancy and the survival of more severely disabled children into adulthood, whilst budgets decreased.

Area A, and in particular the social services in that area, were clearly suffering the effects of major cuts in expenditure. Local reviews had shown service levels to be falling well below the national average, but although some managers hoped that this would prompt the local authority treasurer to release extra funds this was by no means certain to happen. The knock-on effect of such hardship was continual wranglings with health over who should pay for what services, which appeared to make co-operation harder to achieve. Some joint commissioning was being attempted, and there were calls from some managers to pool and ringfence learning disability health and social care budgets, but such co-operation over finances did not seem likely in the near future.

Social services in area B knew that their budget was exactly in line with national targets, and this may well have helped them to accept more stoically any financial difficulties they may have faced. Across the board in this area, health and social service managers realised that their budgets were static or falling, but took this as another reason to collaborate and eliminate wastage rather than seeking to pass the buck wherever possible. As in area A, managers in area B spoke about their desire for budgets to be pooled and ringfenced, but in this case it seemed a distinct possibility whose down side was being assessed, rather than a distant dream.

Private and voluntary sectors

In a reversal of their earlier situation vis a vis implementation of the spirit of the Community Care Act, area A appeared to have contracted out a wider range of services to the private and voluntary sectors than had area B. An increasingly large proportion of both residential and day care in area A was provided by non-statutory organisations, under contract to both health and social services. A few individuals remained ideologically opposed to this process, but not enough to prevent a continuing reliance on this sector. Concerns were raised about whether a true market, rather than a private monopoly, of service providers was being developed and some staff complained that these providers merely cherry-picked the most able clients. Despite these worries however, managers seemed generally content with the situation and keen to encourage greater involvement of the independent sector in the planning process.

By contrast, area B had stuck much more closely to the letter of the Act in the contracting out of services. This was more the case in social services - who were ultimately governed by a staunchly Labour council - than in health, who were not subject to the due processes of local democracy. Within the independent sector this had led to social services contracting with not-for-profit independent providers, but no private sector organisations. Interestingly, however, links with local voluntary pressure groups were actively encouraged, although in an advocacy rather than a provider role.

To summarise, workers in health and social services from both areas shared a number of attitudes and beliefs about central government policies. When it came to translating such policies into practice, however, there were marked differences between the areas in terms of both what they actually did and the degree of inter-organisational co-operation with which they did it.

Chapter 6

Discussion

This final chapter will examine more fully the themes that emerged during analysis of the interview data. Issues will, where relevant, be related back to the theories of implementation outlined in chapter three. Factors affecting inter-agency relations in each of the two research areas will be explored and compared. The chapter will then move on to briefly discuss issues arising from the chosen research methodology. Finally, some insights will be offered into the probable causes of any implementational differences which have become evident between the two areas and suggestions made as to how such difficulties could be minimised in the future.

Emergent themes: i) organisational structure

The first obvious element which emerged from the interview data was the prime importance of organisational structures in influencing both intra- and inter-organisational relationships. Few previous studies have attempted to analyse how organisational structures affect either inter-organisational relationships or policy implementation. One recent American study which did focus on the implementation of new policies across three community centres for the mentally retarded (sic) highlighted the significance of organisational factors in causing a variation in implementation (Becker, Dumas, Houser & Seay, 2000). However, in general, the academic discipline of social policy has had little to say on this matter, leaving it to management and organisational theorists (see Pugh & Hickson, 1996), who tend to analyse such phenomena from the perspective of profit-making companies rather than public sector organisations.

None of the theories of implementation outlined in chapter three start from a full assessment of the structural difficulties currently faced by public sector organisations. Increasing awareness in Whitehall of the need for 'joined up' government, and the subsequent emphasis on inter-agency co-operation (DoH, 1998b), has permeated all aspects of social policy. Explicit policy links (to name but a few) have now been made between education and employment; employment and housing; housing and social services; social services and health; health and leisure; and arching above all this 'social inclusion' at every turn has become the order of the day. Policies are no longer implemented by single government departments, or single local agencies, but are dependent for their successful implementation upon a co-ordinated response from a variety of statutory and non-statutory organisations.

At first glance top-down theorists appear to lay greater stress on the importance of structural issues than do those who favour a bottom-up approach and who emphasise more strongly the impact of human implementers. However, top-down theories have a tendency towards prescribing what should happen, rather than describing empirical evidence. This has led to a chasm opening up between top-down theory and the current reality for public services. In this way top-down implementation theory becomes less an accurate predictor of what difficulties may arise from a given deviation from the 'perfect' model, and more a historical description of the bureaucratic processes of another century.

The policy of providing individualised community care services to adults with learning disabilities cannot be meaningfully mapped as a causal chain of events in the manner proposed by Pressman and Wildavsky (1973). If anything, a network of inter-related elements rather than a causal chain of events is involved in the implementation of current social policies. More importantly, community care policies immediately fall foul of most of the pre-requisites of effective implementation as outlined by both Hood (1976) and

Gunn (1978). Amongst other factors, these models both stress that the policy in question must be implemented by a unitary agency, within which there is perfect communication and co-operation between hierarchical levels, and where the necessary human and financial resources are always available precisely as and when required. None of these essential pre-requisites are evident in the implementation of community care policies for adults with learning disabilities.

However, despite the fact that top-down implementation theories failed to accurately reflect the situations faced within modern public institutions, they continued to have some noticeable purchase with the interviewees. In both research areas, interviewees spoke of their own organisation as typified by 'flat' structures. Some were also equally keen to label organisations other than their own as overly hierarchical and 'bureaucratic'. Both hierarchy and bureaucracy were used as pejorative terms and frontline staff, especially in area A's CLDTs, commonly ascribed these negative values to the working practices of the health service if they were a social worker or social services if they were nurses.

Learning disability services are no exception to the trend which sees policies reliant upon two or more separate agencies for implementation. Indeed, the recent history of learning disability services could be summarised as an ongoing attempt to seek the right balance of provision for this client group from across a wide spectrum of government agencies, which includes health and social services but may also encompass housing, employment, education, leisure, etc. (see, for example, Arblaster et al, 1996 & 1998). Because learning disability, as a human condition, encompasses such a diverse range of potential impairments and abilities the provision of services for this group of individuals often proves problematic. Learning disability certainly does not fall neatly into either of the two categories of care upon which the Community Care Act was predicated. Statutory adult learning disability services are currently provided by both health and social services, but the fact that the needs of this client

group straddle the boundary between health and social care so intractably has created many problems for policy implementation. Moreover, it is the complexity of the issues surrounding the implementation of health and social care services to adults with learning disabilities which has enabled a national policy to result in such extensive variation, and hence inequity, in local service outcomes.

Only Barrett and Fudge (1981) come close to successfully theorising the processes involved as multiple agencies attempt to negotiate the joint implementation of a policy. Their concept of 'action-centred' policy implementation seeks to theorise the interplay between human action and organisational structures and takes into account the possibility that more than one organisation may be involved in implementing a single policy. The very action of implementing a policy, Barrett and Fudge argue, inevitably entails compromise between competing individual or organisational values and this in turn leads, equally inevitably, to a degree of distortion between the original policy and its eventual outcome.

Other theorists, however, have captured different aspects of the policy-implementation interplay. The Community Care Act makes it clear that a distinction must be made, for practical and financial purposes, between health care and social care. The fact that it is not possible to make such a distinction in the case of adults with learning disabilities was the one factor upon which all interviewees (bar one) agreed. Many also stated a belief that the government had set them up to fail by demanding that such a distinction be made, yet not defining how to do so. This is an almost perfect exemplar of the political tactics identified by Lewis (1984) as a common means utilised by government of deliberately obfuscating contentious issues in written policy. In this way contentious issues become the responsibility of local implementers to negotiate, and party politicians are able to maintain their veneer of ideological unity.

Local health and social services are exhorted by central government to collaborate in the provision of 'seamless' care services for people with learning disabilities, yet the barriers to effective inter-agency action remain immense. It would appear that most policies are developed on the preferred premise of top-down theorists, namely that policy making and policy implementation can be distinguished clearly from one another. By assuming that this premise is true, and that the implementation phase commences at some distance from Whitehall, it is possible to imagine that implementation of a policy is undertaken by local agencies. However, before any local factors have a chance to come into play the superstructures within which health and social services must each operate are pulling in opposite directions (see Bulpitt, 1983, for an exploration of political structures and centre-periphery relations in the UK). If government policy-makers took the approach shared by bottom-up theorist, that policy and its implementation are inextricably intertwined, then more attention might usefully be paid to the wider structures through which social policies are delivered.

This section will now undertake a complete analysis of the national and local structures which affected health and social services in this study. By doing so it is hoped to draw out the similarities and differences between the two research areas, and to demonstrate that many of the problems faced by local health and social services cannot easily be overcome simply by staff from different agencies coming together in a spirit of co-operation.

The health service is a national organisation. Actions undertaken and services provided in the name of the NHS are answerable ultimately to the Secretary of State for Health, but local health managers and purchasers have considerable discretion. So long as the decisions which health managers make are not ultra vires they are relatively free to determine how best to make use of available local resources. This means that decisions can be made and implemented relatively quickly, allowing at times for the rapid reconfiguration of existing services. This situation may have both positive and negative aspects. On the

one hand, the ability to rapidly redeploy staff and other resources may enable an organisation to be responsive to the changing needs of the local learning disabled population. On the other hand, this may also mean that decisions are made without sufficient consultation with clients, carers or other organisations and without any active form of public scrutiny. This is a far cry from the situation in which social service managers and commissioners find themselves.

Unlike their counterparts in the health service, social service managers are employed by Local Authorities. Whilst many of the policies which Local Authorities implement are determined by national legislative frameworks, financial resources are allocated to particular departments, including social services, according to the budgetary decisions of the local Council. Upper spending limits of Local Authorities are capped and certain services are required to be provided by law, but within these limitations it is up to local Councillors to decide how monies should be spent. This means that providing services for people with learning disabilities may be a low priority compared to other local needs, which may be as diverse as education and street cleaning.

In some ways this financial status quo echoes the situation within the NHS, where executive managers may choose to divert resources away from services for people with learning disabilities to fund acute care. However, the control that *managers* have over their budgets differs hugely between health and social services. Whereas health managers are broadly-speaking free to manage their budget as best they see fit, those in social services and other local authority departments must seek the approval of the relevant council sub-committee every time they wish to re-allocate resources. This system ensures that resource decisions rest with elected councillors, rather than publicly unaccountable managers, but it also means that the decision-making process is relatively slow. In addition, it may not always be in the best interests of minority groups such as learning disability to be subject to such direct political scrutiny, since they could lose out financially to other, more voter-friendly, causes.

Some, but not all, of the interviewees showed an active awareness of these far-reaching structural problems, which undoubtedly affected their ability to co-operate effectively at local level. No single organisation in the study demonstrated that its staff had a greater than average appreciation of these factors, and knowledge of them was not limited simply to the most senior staff. It seems likely that an awareness of such influences is down to either individual political nous or work experiences which have thrown light on such issues. Several interviewees gave examples of how they had become aware of the existence of such fault lines as they attempted to put together unusual packages of care for individual clients. One of the key original selling points of the community care legislation was its promise of individually-tailored care packages. The fulfilment of this promise was being hampered by a failure of central government to acknowledge the negative effects of its structures. The majority of staff, however, did not appear to have an active awareness of these conflicting superstructures and were more prone to blame local factors for any difficulties in achieving co-operation between health and social services in the provision of care.

In both research areas, there was a tendency for interviewees to excuse the shortcomings of their own organisation and emphasise those of the other. Thus, in both areas, health was criticised by social services for taking important decisions without bothering to consult with anyone else, whilst health complained that social services took too long to make decisions and take action.

In addition to the problems outlined above concerning the incompatibility of the grand structures of the National Health Service with those of Local Authority social services departments, considerable variation in local organisational structures was evident across the research areas. Some of these local variations were again caused by factors beyond the control of local players, but others could potentially be altered to engender more effective

frontline collaboration between health and social services. The differences noted in organisational structure were key to explaining the differences in inter-organisational relationships, and hence implementation, between the two areas. This is because implementation is dependent upon the ability of all necessary local agencies to negotiate and compromise successfully with one another. Where they are unable to do this, seamless implementation will be seriously impaired.

The research interviews provided a huge amount of information concerning the specific, local structural constraints within which services operated. Overall, area A suffered from structural difficulties which were both more numerous and more serious than those identified in area B. These problems related to three distinct factors: geographical boundaries; internal organisational structures; and lines of managerial responsibility and accountability.

The first level of disadvantage facing services in area A was the lack of coterminous geographical boundaries between health and social service organisations. This had resulted in the concept of 'lead agency' becoming redundant, since inter-agency collaboration was not simply a case of bilateral negotiations, but of fathoming relationships clouded by complex overlapping areas of geographical responsibility. The situation in area A was further complicated by the recent upheaval in local government. Where previously there had been a two-tier local system of County and District Councils, there were now two separate systems. The City had become a single-tier Unitary Authority, whilst the remainder of the area had retained its original two-tiered structure. This meant that health had to negotiate not just with two separate organisations, but with two organisations with completely different *modus operandi*.

Secondly, as if the situation outlined above were not enough to contend with, area A's County social services had chosen an internal structure which

appeared to baffle many of its own employees. There was a worrying lack of knowledge shown by CLDT staff of the structures beyond their team, and no discernable means of passing information through the system from frontline workers to service commissioners. The City social services operated within a less complex system which depended in large part upon the abilities of the learning disability service manager to take an effective overview of the population's needs. The fact that health service interviewees in area A spoke of how they found it easier to co-operate with City, as compared to County, social services demonstrates the importance of structure in aiding inter-agency relations. Health staff lacked an understanding of how the County services were structured and this had led to a dearth of positive individual relationships upon which closer organisational links could be based. In particular, the organisational structure adopted by County social services meant that responsibility for learning disability was dispersed across the Districts and, above the level of CLDT team manager hidden under such job titles as "Health and Disability Manager". This lack of a learning disability figurehead made it difficult for people in other organisations to know who held what responsibilities. By contrast, health interviewees knew the City "Learning Disability Service Manager" by name, and knew that this person was the first port of call when seeking to develop new initiatives or solve disputes.

It was not only social service structures which created the difficulties evident in area A: health services also operated in a manner that was not conducive to the creation of positive inter-organisational relationships. The main problem here was the third of the three issues identified earlier: that of a lack of role clarity for various individuals and professional groups. In the upper echelons of area A's health service it was clear that managerial roles had not been adequately defined and that there remained an unspoken battle for power between managers and medics.

Area A's consultants clearly believed that, as both clinicians and senior staff members, they were in the best position to know what was best for the service

as a whole. Whether they were correct in this belief remains a moot point, but there was evidence that the uncertainty which existed over who was in charge made relations with social services more fraught. The inevitable problem for senior social service staff trying to co-operate with the health services was whether the word of NHS managers could be trusted, or whether their position was likely to be undermined at a later date by contradictory medic decisions.

This lack of respect for managers was also evident in some consultant's actions in relation to CLDTs. The consultants' self-righteousness had led them to circumvent certain bilateral systems which had been set up to assist joint working within the CLDTs. By choosing to save time by making referrals directly to community learning disability nurses, rather than making them via CLDT managers, consultants were both undermining the team managers' authority and making it nigh on impossible to manage their teams effectively. This was clearly adding extra and unnecessary strain to an already delicate situation.

The control which these (social worker) CLDT managers had over their team members was further diminished by the fact that the nurses, whom they ostensibly line managed, also received regular supervision from a community nurse manager based at the hospital site. The fact that community nurses in area A felt such supervision to be necessary could again be linked to issues of service structure and professional role definition. Both City and County social services had chosen to have small, patch-based CLDTs. This meant that each team had only one full-time community nurse, which inevitably led to a degree of professional isolation. This, in turn, necessitated outside support as the nurses struggled to maintain the integrity of their nursing role whilst working in an environment dominated by social work values.

Turning now to examine the same issues, of geographic service boundaries, internal organisational structures and lines of managerial responsibility, in area B a very different picture begins to emerge. Firstly, area B benefited

immensely from the fact that the geographical boundaries of health and social services were coterminous. Despite this, there still remained issue over who should take on the mantle of lead agency for learning disability services. This uncertainty rested not on the structural impossibility of determining whether health or social service should take the lead, but on the delicate politics of partnership. Health recognised that lead agency status belonged, in terms of strict government policy, to social services, whilst at the same time believing that they had earned this status themselves by working with the most 'challenging' clients. Social services on the other hand chose to use a language of joint and equal partnership in learning disability services, downplaying the role of lead agency, perhaps as a means of dissipating any potential tension over this issue. In practice, each service had agreed to take the lead in certain areas of learning disability provision, with the result that the issue of lead agency per se became irrelevant.

Secondly, area B's inter-service relations benefited from the fact that health and social services had equally simple internal organisational structures, each of which incorporated clear lines of managerial responsibility and accountability. These straightforward structures enabled interviewees at all levels in both organisations to clearly identify the two individuals, one from health and one from social services, who lead learning disability services. This was a contrast to area A, where staff sometimes lacked knowledge of their own organisation and were very often unsure of the roles fulfilled by particular people in other services. Since organisational relationships are founded upon the individual relationships, this fact was undoubtedly significant in enabling effective communication and co-operation in area B, whilst the lack of such structural and role clarity made organisational relationships in area A considerably harder to develop.

This is not to imply, however, that area B was entirely without structural difficulties. Although working relations between senior managers from health and social services were very good, as were those between nurses and social

workers in the CLDT, there were some indications that staff at intermediate levels had less contact and spoke less positively about colleagues from the opposite organisation. The fact that less contact between services took place at this intermediate level was an inevitable result of the functions fulfilled by these posts. But the fact that those staff, at whatever tier in each organisation, who had reason to actively work together were able to do so effectively gave cause to believe that experience of joint working improved attitudes towards colleagues from other organisations.

It was also evident that some of the same structural problems existed, or had existed, in area B as in area A. One of these issues was around the professional supervision of nurses based within the CLDT. The difficulties in area A relating to this matter have been described above. The situation in area B was somewhat different, although the problem of how a group of professionals could be supervised in a system where their manager was from a different professional background lay at the heart of the matter in both cases. In area B the community nurses commented upon the lack of support they received from their so-called nursing manager, but had instead maintained their professional identity through regular meetings with peer nursing colleagues. In essence, although the system of professional supervision had failed, the organisational structure - which saw many community nurses grouped together in one large CLDT - enabled the nurses themselves to develop a satisfactory alternative support system. Thus it appeared that there were benefits to be gained from larger multi-disciplinary teams in which professional isolation was unlikely to occur.

Another issue, which was spoken about in both research areas, was that of holding joint records for CLDT clients. At the time interviews were conducted some CLDT members in area A seemed quite preoccupied with issues surrounding the introduction of such a shared filing of personal records. Although managers spoke of this as an issue of client confidentiality other staff were more concerned to find practical obstacles to this change and

complained of where shared files might be situated. From an outsider's perspective this could be viewed as petty-minded and a classic example of the goal displacement referred to by Lipsky (1980 & 1981). The CLDT in area B had had a system of shared filing in place for a number of years, but staff were still able to recall similar arguments, concerning confidentiality of health records, taking place in their team when the system had first been set up.

The issue of shared filing was an interesting one because it highlights the interplay between structural systems, individual work practice and aspects of organisational culture. Shared filing is a system of information organisation which has obvious benefits for clients, but in order to introduce it into area A's CLDT some staff will have to adapt their working practices. Since this may entail a slight increase in workload for some individuals they are able to oppose the move, but managers use arguments of client confidentiality in order to justify this opposition. By talking about the issue in these terms it can be made to appear that the needs of the clients, rather than those of the staff, are being put first.

Emergent themes: ii) human factors

A relationship clearly exists between the human and structural factors of any organisation. This relationship is, to a large extent, mediated by managers: the people within an organisation who determine its structures and seek to ensure that other employees act within the confines of these structures. Harding (1998) argues that traditional management theories have little to offer community care services, since they emphasise structure too heavily and overlook the importance of relationships between people. However, the findings from this study suggest that structures are important in enabling personal relationships to flourish.

When directly questioned about the relative importance of organisational structure as compared to individual influence, a variety of opinions were expressed. On the whole interviewees from area A, which had structures less conducive to forming positive inter-agency relationships, expressed more strongly the belief that key individuals played a significant role in determining those relationships. In other words, many interviewees in area A indirectly blamed service managers for not fostering positive inter-organisational relationships. It appeared that, when organisational structures were ineffective, individuals blamed one another for their difficulties rather than stopping to question the structural inadequacies of their organisations. This may, of course, have been a reasonable response given that managers can strongly influence organisational structures. However, it would appear that managers in area A's health service were limited in their powers by the medical lobby, and learning disability managers within the county social services were not placed high enough within the overall organisational hierarchy to wield the power necessary to change existing structures.

In area B, by contrast, where positive relations spread throughout most layers of each service, the structures enabled staff to identify and discursively construct leaders whose positive relationships they could emulate. Managers here appeared to have successfully embraced the ideas outlined by Bate (2000) and understood that public sector management is now less about ensuring control and continuity, and more about being able to work effectively within situations where services are constantly reappraised and changed.

When human factors above the level of the individual were examined there were greater parallels than there were divergences between the two areas. Certain aspects of health and social services culture were talked of in very similar ways. In addition to structurally-determined cultural differences, such as speed of decision-making, cultural signifiers relating to professional background also held true across both areas. The medical model vs. social model was highlighted most strongly when nurses and social workers came

together in CLDTs. Very similar dynamics were apparent in each area, with professions keen to learn from one another, yet equally anxious not to lose their own professional identity.

As the same pattern of cultural difference was observed in two areas with radically different organisational structures and inter-organisational relations it seems probable that this phenomenon is created as a result of the different ideologies inculcated within the two groups involved during their professional training. If inter-professional training for health and social care (Shaw, 1994) is unlikely to become a reality in the near future, such cultural/ideological differences should be taken into account when setting up any service or formulating any policy that necessitates collaboration between nurses and social workers. These two separate professions can clearly work together very effectively, but need certain structures in order to achieve the best possible outcomes. CLDT nurses in area B spoke of maintaining professional roles through support from other nurses in their teams. For nurses in area A, who worked in professional isolation in much smaller multidisciplinary teams, there was no organic support available, and this led to the system of dual supervision which damaged inter-organisational relations.

Emergent themes: ii) policy implementation

So, given the combination of diverse organisational structures yet similar human influences, how did each of the research areas demonstrate co-operative working practices, and how did interviewees verbally construct the notion of policy implementation in their area? A small literature is slowly beginning to emerge which examines the (verbal) social construction of social policies in general (Hastings, 1998) and community care in particular (Symonds & Kelly, 1998). This goes some way towards developing an understanding of the dynamic relationship between what people do and how

they talk about what they do. In this study, it was noticeable that staff in area B not only spoke more positively about the relationship which existed between health and social services, but had also been more successful than staff in area A at creating practical solutions to the problem of co-operative implementation.

Given the massive structural advantages of area B it was not surprising that they appeared to have put policy into practice in a more effective manner than their counterparts in area A. Area B's structures had enabled individual relationships to develop between key individuals from health and social services, which translated into positive constructions of inter-organisational relations. The language of co-operation which emanated from both sides of the health/social services divide helped to create a positive cycle of action and discourse such that the overall relationship continued to improve. Interviewees from both services in area B were able to describe how agreement had been reached over where the boundaries of each service's responsibilities lay and there was little conflict apparent over this issue. In addition, area B had jointly set up a system of assessing and recording need in such a way that the information could be used to determine the shape of future service provision.

Neither of these phenomena was evident in area A. Although assessments of individual need were conducted, as demanded by community care legislation, there was no means of collating such information in order to ascertain the collective needs of the local learning disabled population. Interviewees from both health and social services in area A commonly ascribed this state of affairs to what they deemed to be the chronic under funding of learning disability services. However, not all senior staff upheld this point of view and no interviewees provided numerical evidence of their impoverishment. That is not to say that area A was adequately financed, but merely to suggest that monetary problems provided a blame-free vehicle upon which staff could cast the fault for any perceived service failures. For example, there were approximately twice as many nurses in area B's CLDT as in all of area A's

CLDTs put together. This may have been because area A was seriously under funded, or may have been because the area had retained a relatively large in-patient facility that soaked up much of the available nursing resources.

In addition to the empirical evidence of working practice with regard to implementation, there was also a distinct difference in the way in which interviewees from each area talked about the process of policy implementation. In both areas, however, it was largely senior members of staff who made the majority of comments upon this topic. Senior staff in area A spoke of how they had introduced changes to their services well before they had been mandated to do so by government legislation. They felt that policy had been led by local factors, pointing to the early closure of the Victorian mental handicap hospital and pioneering establishment of CLDTs. By contrast, managers in area B spoke of change being driven by legislation. This was noteworthy because managers in area B were also much less likely to be critical of government policy than their counterparts in area A. What remained unclear was whether or not a dynamic relationship existed between failure to effectively implement community care policies for adults with learning disabilities and disenchantment with the policy itself.

Some of the principle tenets of bottom-up implementation theory were given credence through the manner in which frontline staff in both areas talked about policy implementation. These lower-level actors tended to perceive policy as being determined more locally than was believed to be the case by their managers. This tallies with the premise that policy and implementation are part of the same continuum (Barrett & Fudge, 1981; Palumbo & Harder, 1981; Lewis, 1984) and cannot rationally be regarded as separate processes: the experience of frontline workers is that their managers largely determine workplace policy.

Methodological issues

As with any social research, particularly that which is qualitative in nature, the question of reflexivity must be addressed (see King, 1993 and Smith, 1993 for discussions of this issue). It is never possible to remove the influences of the interviewer from a study such as this, but it is possible to identify some of the ways in which reflexive factors may have affected both data gathering and analysis.

Prior to interviews taking place, I had had some limited contact with the consultant psychiatrists and psychologists in area A, but had not met any of the other health or social services staff. In the case of area B, I had met health's Director of Learning Disability Services at a conference, but met all other interviewees for the first time at interview. No obvious differences were discernible between interviewees with whom there had or had not been previous contact, but the chance that this may have influenced the interviews cannot be ruled out.

All of the interviews in area A were completed before any interviews were undertaken in area B. My interviews in area A revealed considerable difficulties in the working relationship between health and social services. I embarked upon interviews in area B expecting to find a similar degree of friction. The low expectations with which I approached the subject of inter-agency co-operation in area B may therefore have led me to be over-impressed by the comparatively congenial relationship which existed in that area between health and social services.

Every interviewee began with an 'ice breaker' question, inquiring how long the interviewee had worked in the field of learning disability and, in general, interviewees appeared relaxed during interviews. Many expressed their views in a very forthright manner. I made a conscious decision to agree with

whatever opinions interviewees chose to espouse in order to minimise the chance that interviewees would be deterred from speaking out.

One aspect of the interviews that was, upon reflection, perhaps misguided was the use of the word 'ideology' (as in questions such as: "Have you ever been aware of any ideological conflict between staff from the health service and those from social services?"). During examination of the transcripts it became apparent that many interviewees had reacted negatively to the use of this terminology. The word 'ideology' seemed to be viewed by many interviewees as having negative connotations. I had been using it to mean "the set of beliefs characteristic of a social group or individual" (Concise Oxford Dictionary, 1999), but it would seem to have been taken by many as indicative of adherence to a set of beliefs that were politically motivated or based upon questionable theory, rather than grounded in reality.

A second aspect of the methodology which may have influenced the research findings was the time period over which interviews took place. When interviewing began in area A the Labour administration of Tony Blair had been in place for just over a year and its character was slowly starting to emerge. One or two interviewees mentioned the 'managerialist' approach which they believed the new government was taking towards matters of social policy. Many, many more commented upon the deluge of consultation and guidance documents that were constantly being churned out by Whitehall during the time span of the research. The timing of some of these publications may have had a particular influence upon the research findings. For example, early interviewees in area A were concerned about the implications for learning disability services of the Primary Care Groups; interviewees in area B had seen these begin to operate without greatly affecting their services.

Conclusion

Government policy pertaining to the provision of health and social care services for adults with learning disabilities requires a collaborative approach from local health and social services. Effective working relationships must therefore be established between separate statutory organisations in order for policy to be implemented in the manner prescribed. Numerous barriers exist to the formation of the necessary degree of inter-organisational co-operation, many of which are beyond the ability of local actors to influence. Additional barriers may also exist at a local level.

The structures chosen by local organisations greatly affect their ability to work co-operatively and collaboratively. Structures significantly determine the ability of staff to identify, and therefore relate to, important individuals in both their own and other organisations. Structures which do not allow individual roles and responsibilities to be clearly understood impair the development of positive inter-organisational relationships and hence mitigate against policy implementation. Organisational structures also influence the way in which individual staff members construct notions of leadership, co-operation and conflict. However, cultural divisions between health and social services staff appear largely to be determined by professional ideologies acquired during training. Such cultural divisions have some bearing upon inter-organisational relations, but may be either diminished or exacerbated by structural factors.

The data gathered during this research exercise gave partial support to many of the existing theories of policy implementation. However, none of these theories was successful in capturing both the relationship between politics and policy and the dynamic interaction between staff and structure within local organisations.

Those who develop public policy have yet to pay sufficient attention to these complex implementation issues. At a national level, governments are gradually

beginning to acknowledge that agencies must be enabled (rather than forced) to co-operate (e.g. DoH, 1998b), but the fundamental barriers that current structures pose to achieving such co-operation have yet to be seriously addressed. At a local level, too little attention has been paid to what sociologists (see, for example, Craib, 1984) would term the agency-structure debate. A fuller understanding of how human behaviour within organisational settings derives from organisational structures, and vice versa, is needed.

Learning disability services, because of their position on the cusp of two separate agencies, provide fertile ground for the examination of many issues pertinent to policy implementation. Future prospects for improving equity in the implementation of policies which straddle traditional agency boundaries in this way could be enhanced by separating out those factors which can effectively be addressed by local actors from those which are in the hands of central government.

Chapter 7

Epilogue: Valuing People

In March 2001 the Department of Health published the first White Paper (Cmnd 5086) concerning learning disability services for thirty years. Entitled "Valuing People: A New Strategy for Learning Disability for the 21st Century", the document lays out a vision for the future of learning disability services based on the 'key principles' of rights, independence, choice and inclusion. It also promises that more financial support for learning disability services will be made available through a centrally administered Learning Disability Development Fund. The majority of the document lays out in some detail the various areas of learning disability service provision which need to be expanded or improved. These include the transition from child to adult services; support for carers; advocacy services; health care; day services; housing; employment opportunities; and meeting the particular needs of people with learning disabilities who come from ethnic minority communities. The penultimate chapter addresses the issue of partnership working between various public, voluntary and private agencies in order to meet the needs identified.

Financially, the headline news from this White Paper appears good. The Government estimates that £3 billion of public money is currently spent annually on learning disability services. An extra £50 million per year is promised for the Learning Disability Development Fund to distribute. On the face of it this constitutes a significant increase in funding. However, this figure is made up of £20 million for capital developments and 'up to' £30 million per annum of revenue expenditure. Importantly, the revenue monies are linked explicitly to the release of cash from the reprovision 'over time' of old long-stay facilities. This would therefore appear not to be new money, but money which has been repeatedly promised to community-based learning disability

services over the past two decades. The capital monies will be made available to individual authorities through a bidding process.

The most significant proposals relating to co-operative working between local health and social services are those which concern the establishment of 'Learning Disability Partnership Boards'. The make-up and operation of such boards is laid out in more detail in a joint health and local authority circular (HSG 2001/016: LAC[2001]23). This circular replaces the two circulars "Social Care for Adults with Learning Disabilities (Mental Handicap)" (LAC[92]15) and "Health Services for People with Learning Disabilities (Mental Handicap)" (HSG[92]42) which had previously formed the backbone of policy guidance for community care services to this client group.

The Learning Disability Partnership Boards must be set up by October 2001, one covering the geographical area of each local council. Boards will be chaired by a representative of the council (either a senior local government officer or an elected councillor) and will include in their membership representatives from social services; all relevant health bodies (including health authorities and trusts); housing; education; employment services and representatives from both voluntary organisations and independent service providers.

So, bearing in mind the findings of this thesis, what hope does this raft of proposals offer to learning disability services? Firstly it has to be said that for a 'new' vision, these principles bear a remarkable similarity to the 'five accomplishments' (community presence, choice, competence, respect and social participation) set out by O'Brien and Tyne in 1981 as benchmarks against which to measure the progress of normalisation within learning disability services. On this basis it would seem that the White Paper is reiterating much that has been said before elsewhere. However, any government commitment to this client group must be welcomed and it perhaps

says much about past failures to deliver that the same principles require reiteration two decades on.

The Learning Disability Partnership Boards could be viewed cynically as yet another attempt by central government to engender effective co-operation between health and social services at a local level. However, this time the scope of co-operation demanded goes much further, encompassing *all* the key agencies which have a part to play in enhancing the lives of people with learning disabilities. Such a broadening of horizons is certainly to be welcomed, even if past experience demonstrates how hard it is to achieve effective co-operation between just two agencies.

One of the issues highlighted in this thesis was the difficulty faced by health and social services attempting to co-operate across geographical boundaries which were not coterminous. It is to be expected that this will remain a stumbling block during the implementation of the proposals in the White Paper. However, by stipulating that a senior representative from the local authority must chair the Boards, the issue of whether health or social services should be lead agency for this client group appears to have finally been settled.

Of course, the pressing question of how to mandate co-operation between health and social service elements of learning disability provision remains. In this respect the White Paper appears to offer an unexpected ray of hope. All of the monies, both capital and revenue, which are to be made available for learning disability services will only be available as pooled funds. In effect this forces local health and social services to use the flexible financial arrangements which were made available to them on a voluntary basis under the 1999 Health Act. Past experience demonstrates that money is more effective than mere rhetoric at eliciting co-operation. It is to be hoped, therefore, that this proviso will act as the catalyst which enables the vision of a learning disability service based on rights, independence, choice and inclusion to finally emerge.

Chapter 8

References

Alaszewski, A. (1988)

"From Villains to Victims"

in A. Leighton (ed.) "Mental Handicap in the Community"

Cambridge: Woodhead-Faulkner

Alaszewski, A. & Ong, B. (eds.) (1990)

"Normalisation in Practice"

London: Routledge

Arblaster, L., Conway, J., Foreman, A. & Hawtin, M. (1996)

"Inter-agency working for housing, health and social care needs of people in general needs housing"

Housing Research Findings no. 183, June 1996

Joseph Rowntree Foundation

Arblaster, L., Conway, J., Foreman, A. & Hawtin, M. (1998)

"Achieving the Impossible: interagency collaboration to address the housing, health and social care needs of people able to live in ordinary housing"

Bristol: Policy Press and the Joseph Rowntree Foundation

Audit Commission (1986)

"Making a Reality of Community Care"

London: HMSO

Audit Commission (1989)

"Developing Community Care for Adults with a Mental Handicap"

London: HMSO

Audit Commission (1992a)

"Homeward Bound: A New Course For Community Health"

London: HMSO

Audit Commission (1992b)
"The Community Revolution: Personal Social Services and Community Care"
London: HMSO

Audit Commission (1992c)
"Community Care: Managing the Cascade of Change"
London: HMSO

Audit Commission (1994)
"Taking Stock: Progress with Community Care"
London: HMSO

Audit Commission (1996)
"Balancing the Care Equation: Progress with Community Care"
London: HMSO

Baldwin, S. (1993)
"The Myth of Community Care"
London: Chapman & Hall

Baldwin, S. & Hattersley, J. (eds.) (1991)
"Mental Handicap: Social Science Perspectives"
London: Routledge

Baldwin, S. & Lunt, N. (1996)
"Local Authority Charging Policies for Community Care"
Joseph Rowntree Foundation: Social Care Research Findings 88

Barrett, S. & Fudge, C. (eds.) (1981)
"Policy and Action: Essays on the Implementation of Public Policy"
London: Methuen

Bate, P. (2000)
"Health Services Management Centre Newsletter"
(University of Birmingham School of Public Policy)
Vol. 6, issue 2, pp.2

- Beacock, C. & Tait, T. (1997)
 "Economic Dimensions of Learning Disability"
 in B. Gates (ed.) "Dimensions of Learning Disability"
 London: Balliere Tindall
- Becker, H., Dumas, S., Houser, A. & Seay, P. (2000)
 "How Organizational Factors Contribute to Innovations in Service Delivery"
 Mental Retardation
 Vol. 38, no. 5, pp. 385-394
- Beecham, J., Hallam, A., Knapp, M., Baines, B., Fenyo, A. & Asbury, M. (1997)
 "Costing Care in Hospital and in the Community"
 in J. Leff (ed.) "Care in the Community: Illusion or Reality?"
 Chichester: John Wiley & Sons
- Begg, D., Fischer, S. & Dornbusch, R. (1991, 3rd edition)
 "Economics"
 Maidenhead: McGraw-Hill
- Blumenthal, S., Lavender, T., & Hewson, S. (1998)
 "Role Clarity, Perception of the Organization and Burnout Amongst Support Workers in
 Residential Homes for People with Intellectual Disability"
 Journal of Intellectual Disability Research
 Vol. 42, part 5, pp. 409-417
- Bornat, J., Pereira, C., Pilgrim, D. & Williams, F. (eds.) (1993) "Community Care: A Reader"
 Basingstoke: Macmillan
- British Medical Association (1995)
 "Survey on the Impact of the Implementation of the Community Care Reforms"
 London: BMA
- Brown, B., Crawford, P. & Darongkamas, J. (2000)
 "Blurred Roles and Permeable Boundaries: The Experience of Multidisciplinary Working in
 Community Mental Health"
 Health and Social Care in the Community
 Vol. 8, part 6, pp.425-435

Brown, H. & Smith, H. (eds.) (1992)

"Normalisation: A Reader for the Nineties"

London: Routledge

Bulpitt, J. (1983)

"Territory and Power in the United Kingdom"

Manchester: Manchester University Press

Burnard, P. (1991)

"A Method of Analysing Interview Transcripts in Qualitative Research"

Nurse Education Today

Vol. 11, pp. 461-466

Burton, M. & Kellaway, M. (1995)

"Specialization without Separation: combining health and social service provision for people with learning disabilities"

Health and Social Care in the Community

Vol. 3, part 4, pp.263-270

Cambridge, P. & Knapp, M. (eds.) (1988)

"Demonstrating Successful Care in the Community"

PSSRU: University of Kent at Canterbury

Cambridge, P., Hayes, L. & Knapp, M. (1994)

"Care in the Community: Five Years On - Life in the Community for People with Learning Disabilities"

Aldershot: Ashgate

Cambridge, P., Hayes, L. & Knapp, M. (1996)

"`Care in the Community` five years on"

Tizard learning Disability Review

Vol. 1, issue 3, July 1996

Cassell, C. & Symon, G. (1994)

"Qualitative Research in Work Contexts"

in Cassell, C. & Symon, G. (eds.) "Qualitative Methods in Organizational Research: A Practical Guide"

London: Sage

Castellani, P. (1992)

"Closing Institutions in New York State: Implementation and management lessons"

Journal of Policy Analysis and Management

Vol. 11, no. 4, pp.593-611

Challis, L., Fuller, S., Henwood, M., Klein, R., Plowden, W., Webb, A., Whittingham, P. &

Wistow, G. (1988)

"Joint Approaches to Social Policy"

Cambridge: Cambridge University Press

Chant, J. (1986)

"Making Ends Meet - A Continuum of Care"

in G. Wilkinson (ed.) "The Provision of Mental Health Services in Britain: The Way Ahead"

London: Gaskell

Clarke, A.D. & Clarke, A.M. (1991)

"Research on Mental Handicap: Past, Present and Future"

in Segal, S. & Varma, V. (eds.) "Prospects for People with Learning Disabilities"

London, David Fulton

Cm 3807 (1998)

"The New NHS: Modern, Dependable"

London: HMSO

Cm 3852 (1998)

"Our Healthier Nation: A Contract for Health"

London: HMSO

Cm 4169 (1998)

"Modernising Social Services: Promoting Independence, Improving Protection, Raising Standards"

London: HMSO

Cm 5086 (2001)

"Valuing People: A New Strategy for Learning Disability for the 21st Century"

London: DoH

Cmnd 7468 (1979)

"Report of the Committee of Enquiry into Mental Handicap Nursing and Care" (Jay Report)
London: HMSO

Cmnd 4683 (1971)

"Better Services for the Mentally Handicapped"
London: HMSO

Concise Oxford Dictionary: Tenth Edition (1999)

Oxford: Oxford University Press

Craib, I. (1984)

"Modern Social Theory: From Parsons to Habermas"
Hemel Hempstead: Harvester Wheatsheaf

Cutler, T. & Waine, B. (2000)

"Managerialism Reformed? New Labour and Public Sector Management"
Social Policy and Administration
Vol. 34, no. 3, pp. 318-332

Dagnan, D., Ruddick, L. & Jones, J. (1998)

"A Longitudinal Study of the Quality of Life of Older People with Intellectual Disability After Leaving Hospital"
Journal of Intellectual Disability Research
Vol. 42, part 2, pp. 112-121

Davidson, S. (1976)

"Planning and Coordination of Social Services in Multi-organizational Contexts"
Social Service Review
Vol. 50, part 1, pp. 117-137

Davies, B. & Knapp, M. (1994)

"Improving Equity and Efficiency in British Community Care"
Social Policy and Administration
Vol. 28, no. 3, pp. 263-285

Davies, L. (1987)

"Quality, Costs and `An Ordinary Life`"
London: King's Fund, Project Paper no. 67

Department of Health (1992)

"Statistical Bulletin 3(6) 92: Personal Social Services: Provision for People with Learning Disabilities, England 1979-1991"

London: Government Statistical Service

Department of Health (1995)

"Community Care: Detailed statistics on local authority personal social services for adults, England 1994"

London: Government Statistical Service

Department of Health (1998a)

"Signposts for Success in Commissioning and Providing Health Services for People with Learning Disabilities" (Lindsey, J.)

London: DoH

Department of Health (1998b)

"Partnership in Action (New Opportunities for Joint Working between Health and Social Services)"

London: DoH

Department of Health (1998c)

"Moving into the Mainstream: The Report of a National Audit of Services for Adults with Learning Disabilities" (Fruin, D.)

London: DoH

Department of Health (1999a)

"Once a Day" (Lindsey, J. & Russell, O.)

London: DoH

Department of Health (1999b)

"Facing the Facts: Services for People with Learning Disabilities: A Policy Impact Study of Social Care and Health Services"

London: DoH

DHSS (1987)

"Mental Handicap: Progress, Problems and Priorities"

London: HMSO

Digby, A. (1996)

"Contexts and Perspectives"

in Wright, D. & Digby, A. "From Idiocy to Mental Deficiency"

London: Routledge

Dunsire, A. (1978)

"Implementation in a Bureaucracy"

Oxford, Martin Robertson

Elwell, L., Platts, H. & Rees, G. (1995)

"Putting People First?: Assessment and care management"

in T. Philpot & Ward, L. (eds.) "Values and Visions: Changing Ideas in Services for People with Learning Disabilities"

Oxford: Butterworth-Heinemann)

Evandrou, M., Falkingham, J., Le Grand, J. & Winter, D. (1992)

"Equity in Health and Social Care"

Journal of Social Policy

Vol. 21, no. 4, pp. 489-523

Felce, D. (1996)

"Community Housing Costs"

Tizard Learning Disability Review

Vol. 1, issue 1, pp. 39-43

Felce, D. (1996)

"Changing Residential Services: From Institutions to Ordinary Living"

in P. Mittler & Sinason, V. (eds.) "Changing Policy and Practice for People with Learning Disabilities"

London: Cassell

Fowler, P., Hannigan, B. & Northway, R. (2000)

"Community Nurses and Social Workers Learning Together"

Health and Social Care in the Community

Vol. 8, part 3, pp.186-191

Fraser, D. (1984)

"The Evolution of the British Welfare State" (2nd edition)

Basingstoke, Macmillan

Fruin, D (1998)

"Moving Into the Mainstream: A Report of a National Inspection of Services for Adults with Learning Disabilities"

London: Department of Health/Social Services Inspectorate

Getliffe, C. (1996)

"Alternative Communities"

in P. Mittler & Sinason, V. (eds.) "Changing Policy and Practice for People with Learning Disabilities"

London: Cassell

Gladstone, D. (1996)

"The Changing Dynamic of Institutional Care"

in Wright, D. & Digby, A. (eds.) "From Idiocy to Mental Deficiency"

London: Routledge

Glaser, B. & Strauss, A. (1967)

"The Discovery of Grounded Theory: Strategies for Qualitative Research"

Chicago: Aldine

Glennerster, H. (1992)

"Paying for Welfare: The 1990s"

Hemel Hempstead: Harvester Wheatsheaf

Glennerster, H., with Korman, N. & Marsden-Wilson, F. (1983)

"Planning for Priority Groups"

Oxford: Martin Robertson

Glennerster, H. & Korman, N. (1986)

"From Institution to Community Services"

in Wilkinson, G. & Freeman, H. (eds.) "The Provision of Mental Health Services in Britain: The Way Ahead"

London: Gaskell

Goffman, E. (1961)

"Asylums"

New York: Anchor Books

Goodey, C. (1996)

"The Psychopolitics of Learning and Disability in Seventeenth-Century Thought"

in Wright, D. & Digby, A. "From Idiocy to Mental Deficiency"

London: Routledge

Graham, H (1993)

"Feminist Perspectives on Caring"

in Bornat, J., Pereira, C., Pilgrim, D. & Williams, F. (eds.) "Community Care: A Reader"

Basingstoke: Macmillan

Grant, G. & Wray, K. (1986)

"CMHTs, Service Delivery and Service Development"

in Grant, G., Humphreys, S. & McGrath, M. "Community Mental Handicap Teams: Theory and Practice"

BIMH Conference Series

Greig, R. (199?)

"Joint Commissioning: Searching for Stability in an Unstable World"

Tizard Learning Disability Review

Vol. 2, issue 1, pp. 19-30

Griffiths, R. (1988)

"Community Care: Agenda for Action"

London: HMSO

Gunn, L. (1978)

"Why Is Implementation So Difficult?"

Management Services in Government

November 1978, pp. 169-176

Hadley, R. & Clough, R. (1996)

"Care in Chaos: Frustration and Challenge in Community Care"

London: Cassell

Ham, C. & Hill, M. (1984)

"The Policy Process in the Modern Capitalist State"

London: Harvester-Wheatsheaf

Hampshire-Monk, I. (1992)

"A History of Modern Political Thought"

Oxford: Blackwell

Harding, N. (1998)

"The Social Construction of Management"

in Symonds, A. & Kelly, A. "The Social Construction of Community Care"

Basingstoke, Macmillan

Hardy, B., Wistow, G. & Rhodes, R. (1990)

"Policy Networks and the Implementation of Community Care Policies for People with Mental Handicaps"

Journal of Social Policy

Vol. 19, part 2, pp. 141-168

Hastings, A. (1998)

"Connecting Linguistic Structures and Social Practices: A Discursive Approach to Social Policy Analysis"

Journal of Social Policy

Vol. 27, no. 2, pp. 191-211

Hattersley, J. (1991)

"The Future of Normalisation"

in Baldwin, S. & Hattersley, J. (eds.) "Mental Handicap: Social Science Perspectives"

London: Routledge

Hatton, C., Rivers, M., Mason, H., Mason, L., Emerson, E., Kiernan, C., Reeves, D. & Alborz, A. (1999)

"Organizational Culture and Staff Outcomes in Services for People with Intellectual Disabilities"

Journal of Intellectual Disability Research

Vol. 43, part 3, pp. 206-218

Heginbotham, C. (1990)

"Return to the Community: Voluntary Ethic and Community Care"

London: Bedford Square Press

Henwood, K. (1993)

"Women and Later Life: the discursive construction of identities within family relationships"

Journal of Ageing Studies

Vol. 7, pp. 303-385

Henwood, M., Jowell, T. & Wistow, G. (1991)

"All Things Come (To those Who Wait?): causes and consequences of the community care delays"

London: Kings Fund Institute

Higgins, R. (1994)

"Working Together: Lessons for Collaboration Between Health and Social Services"

Health & Social Care in the Community

Vol. 2, pp.269-277

Higgins, R. & Richardson, A. (1994)

"Into the Community: A Comparison of Care Management and Traditional Approaches to Resettlement"

Social Policy & Administration

Vol. 28, no. 3, pp.221-235

Hill, M. (1981)

"The Policy-Implementation Distinction: a quest for rational control?"

in Barrett, S. & Fudge, C. (eds) "Policy and Action: Essays on the Implementation of Public Policy"

London: Methuen

Holland, S. (1987)

"The Market Economy"

London: Weidenfeld & Nicolson

Hood, C. (1976)

"The Limits of Administration"

London: Wiley

Hoyes, L. & Means, R. (1993)

"Markets, Contracts and Social Care Services: Prospects and Problems"

in Bornat, J., Pereira, C., Pilgrim, D. & Williams, F. (eds.) "Community Care: A Reader"

Basingstoke: Macmillan

Hoyes, L., Means, R. & Le Grand, J. (1992)

"Made to Measure? Performance Measurement and Community Care"

Bristol: SAUS, Occasional Paper no. 39

HSG[92]42 (1992)

"Health Services for People with Learning Disabilities (Mental Handicap)"

London: DoH

HSG 2001/016: LAC[2001]23

"Valuing People: A New Strategy for Learning Disability for the 21st Century:
Implementation Guidance"

London: DoH

Hudson, B. (1994)

"Community Care One Year On: An Implementation Deficit?"

in A. Harrison (ed.) "Health Care UK 1993/94"

London: Kings Fund Institute

Hudson, B. (1995a)

"A Seamless Service? Developing better relationships between the National Health Service
and Social Services Departments."

in Philpot, T. & Ward, L. (eds.) "Values and Visions"

Oxford: Butterworth-Heinemann

Hudson, B. (1995b)

"Is a co-ordinated service attainable?"

in Malin, N. (ed.) "Services for People with Learning Disabilities"

London: Routledge

Hudson, H. (1993)

"Needs-Led Assessment: Nice Idea, Shame About the Reality?"

Health and Social Care in the Community

Vol. 1, part 2, pp.115-119

Hunter, D. & Wistow, G. (1987)

"Community Care in Britain: Variations on a Theme"

London: King Edwards Hospital Fund for London

Hyder, M. (1984)

"Implementation: The Evolutionary Model"

in Lewis, D. & Wallace, H. (eds.) "Policies into Practice"

London: Heinemann

Jay, P. in association with Tizard, J. (1996)

"Exodus: Bringing Children Out of Hospital"

in Mittler, P. & Sinason, V. (eds.) "Changing Policy and Practice for People with Learning Disabilities"

London: Cassell

Jones, K. (1960)

"Mental Health and Social Policy"

London: Routledge & Kegan Paul

Jones, K., Brown, J. & Bradshaw, J. (1983)

"Issues in Social Policy" (revised edition)

London: Routledge & Kegan Paul

King, E. (1993)

"The use of the Self in Qualitative Research"

in Richardson, T. (ed.) "Handbook of Qualitative Research Methods"

Leicester: BPS Books

Knapp, M., Cambridge, P., Thomason, C., Beecham, J., Allen, C. & Darton, R. (1992)

"Care in the Community: Challenge and Demonstration"

Aldershot: Ashgate

Korman, N. & Glennerster, H. (1990)

"Hospital Closure"

Buckingham: Open University Press

LAC[92]15 (1992)

"Social Care for Adults with Learning Disabilities (Mental Handicap)"

London: DoH

Laing, W. (1993)

"Financing Long-Term Care"

London: Age Concern England

Leff, J. (1997)

"Care in the Community: Illusion or Reality?"

Chichester: John Wiley & Sons

Leighton, A. (ed.) (1988)

"Mental Handicap in the Community" (introduction)

Cambridge: Woodhead-Faulkner

Lewis, D. (1984)

"Improving Implementation"

in Lewis, D. & Wallace, H. (eds.) "Policies into Practice"

London: Heinemann

Lewis, J. & Glennerster, H. (1996)

"Implementing the New Community Care"

Buckingham: Open University Press

Lipsky, M. (1980)

"Street-Level Bureaucracy: Dilemmas of the Individual in Public Services"

New York: Russell Sage Foundation

Lipsky, M. (1981)

"The Welfare State as Workplace"

Public Welfare/Summer 1981

Vol. 39, no. 3, pp.22-27

Lipsky, M. (1984)

"Bureaucratic Disentitlement in Social Welfare Programs"

Social Service Review/March 1984

Vol. 58, no. 1, pp. 3-27

Lipsky, M. & Smith, S. (1989)

"Nonprofit Organizations, Government and the Welfare State"

Political Science Quarterly/Winter 1989-90

Vol. 104, no. 4, pp.625-648

- Lugton, J. (1997)
 "The Nature of Social Support as Experienced by Women Treated for Breast Cancer"
 Journal of Advanced Nursing
 Vol. 25, pp. 1184-1191
- MacDonald, I. (1990)
 "Similarities and differences Between Client Groups"
 in Sharkey, S. & Barna, S. "Community Care: People leaving long-stay hospitals"
 London: Routledge
- Malin, N. (ed.) (1995)
 "Services for People with Learning Disabilities"
 London: Routledge
- Mandelstam, M. with Schwehr, B. (1995)
 "Community Care Practice and the Law"
 London: Jessica Kingsley
- Mansell, J. (1999)
 "Deinstitutionalisation and Community Services in Greater Glasgow"
 Tizard Learning Disability Review
 Vol. 4, issue 1, January 1999
- Mansell, J. (2000)
 "The Quality and Costs of Village Communities, Residential Campuses and Community-Based Residential Supports for People with Learning Disabilities"
 Tizard Learning Disability Review
 Vol. 5, issue 1, January 2000
- Mansell, J. & Ericsson, K. (1996)
 "Deinstitutionalisation in Britain, Scandinavia and the USA"
 Tizard Learning Disability Review
 Vol. 1, issue 1, January 1996
- Marshall, C. & Rossman, G. (1995)
 "Designing Qualitative Research" (2nd edition)
 London: Sage

Marshall, H. (1994)

"Discourse Analysis in an Occupational Context"

in: Cassell, C. & Symon, G. (eds.) "Qualitative Methods in Organizational Research: A Practical Guide"

London: Sage

Maykut, P. & Morehouse, R. (1994)

"Beginning Qualitative Research: A Philosophic and Practical Guide"

London: The Falmer Press

Maynard-Moody, S., Musheno, M. & Palumbo, D. (1990)

"Street-wise Social Policy: Resolving the Dilemma of Street-Level Influence and Successful Implementation"

Western Political Quarterly

Vol. 43, no. 4, pp.833-848

Mazmanian, D. & Sabatier, P. (1989)

"Implementation and Public Policy"

Lanham: University Press of America

McCarthy, M. & Cameron, A. (1992)

"Facing the Cuts: A Health Authority's Experience of Rate-capping"

Public Health

Vol. 106, pp. 271-276

McLean, T. (1988)

"Closing the Hospitals and Changing Provision"

in Leighton, A. (ed.) "Mental Handicap in the Community"

Cambridge, Woodhead-Faulkner

McGrath, M. & Grant, G. (1992)

"Supporting `Needs-Led` Services: implications for Planning and Management Systems (A case study in mental handicap services)"

Journal of Social Policy

Vol. 21, part 1, pp.71-97

- McGrowther, C., Hauck, A., Bhaumik, S., Thorp C. & Taub, N. (1996)
 "Community Care for Adults with Learning Disability and Their Carers: Needs and Outcomes from the Leicestershire Register"
 Journal of Learning Disability Research
 Vol. 40, part 2, pp.183-190
- Means, R. & Smith, R. (1994)
 "Community Care: Policy and Practice"
 London: Macmillan
- Meyers, M., Glaser, B. & MacDonald, K. (1998)
 "On the Front lines of Welfare Delivery: Are Workers Implementing Policy Reforms?"
 Journal of Policy Analysis
 Vol. 17, no. 1, pp. 1-22
- Mittler, P. (1996)
 "Advocates and Advocacy"
in Mittler, P. & Sinason, V. (eds.) "Changing Policy and Practice for People with Learning Disabilities"
 London: Cassell
- Mommsen, W. (1989)
 "The Political and Social Theory of Max Weber"
 Cambridge: Polity Press
- Morris, J. (1991)
 "Pride Against Prejudice"
 London: Women's Press
- Morris, P. (1969)
 "Put Away"
 London: Routledge & Kegan Paul
- Nocon, A. (1994)
 "Collaboration in Community Care in the 1990s"
 Sunderland: Business Education Publishers

- O'Brien, J. & Tyne, A. (1981)
"The Principle of Normalisation: A Foundation for Effective Services"
London: Campaign for People with Mental Handicaps
- Office of Population, Censuses and Surveys (1992)
"1991 Census: County Reports"
London: HMSO
- Ovretveit, J. (1993)
"Co-ordinating Community Care"
Buckinghamshire: Open University Press
- Parker, G. (1990)
"With Due Care and Attention: a review of research on informal care"
London: Family Policy Studies Centre
- Parker, R. (1988)
"An Historical Background"
in Sinclair, I. (ed.) "Residential Care: The Research Reviewed"
London: HMSO
- Pearson, M. & Wistow, G. (1995)
"The Boundary Between Health Care and Social Care"
British Medical Journal
Vol. 311, July 1995, pp. 208-209
- Perkins, E. & Allen, I. (1997)
"Creating Partnerships in Social Care"
London, Policy Studies Institute
- Pettigrew, A., Ferlie, E. & McKee, L. (1992)
"Shaping Strategic Change"
London: Sage
- Philpot, T. & Ward, L. (1995)
"Values and Visions"
Oxford: Butterworth-Heinemann

- Pidgeon, N. (1996)
 "Grounded Theory: Theoretical Background"
in Richardson, J. (ed.) "Handbook of Qualitative Research Methods"
 Leicester: BPS Books
- Potter, J. & Wetherall, M. (1987)
 "Discourse and Social Psychology"
 London: Sage
- Pressman, J. & Wildavsky, A. (1973)
 "Implementation"
 Berkeley, University of Los Angeles Press
- Prosser, H. & Moss, S. (1996)
 "Informal Care Networks of Older Adults with an Intellectual Disability"
 Journal of Intellectual Disability Research
 Vol. 9, part 1, pp. 17-30
- Pugh, D. & Hickson, D. (1996)
 "Writers On Organizations" (5th edition)
 Harmondsworth: Penguin
- Raynes, N. (1991)
 "Obstacles to Community Care"
in Segal, S. & Varma, V. "Prospects for People with Learning Disabilities"
 London: David Fulton
- 'Rescare': see newspaper reports (1995)
 i) The Guardian, 15th February 1995, "Into a Caring Community"
 ii) The Independent, 27th March 1995, "Care Policy for Mental Handicap to be Reviewed"
- Richardson, A. (1995)
 "Caremanagement"
in N. Malin (ed.) "Services for People with Learning Disabilities"
 London, Routledge

Richardson, A. & Higgins, R. (1993)

"Implementing Care Management"

Social Care Research Findings No. 33, April 1993

Joseph Rowntree Foundation

Richardson, S. & Pearson, M. (1995)

"Dignity and Aspirations Denied: Unmet Health and Social Care Needs in an Inner-City Area"

Health & Social Care in the Community

Vol. 3, part 5, pp. 279-287

Robertson, J., Moss, S. & Turner, S. (1996)

"Policy, Services and Staff Training for Older People with Intellectual Disability in the UK"

Journal of Applied Research in Intellectual Disabilities

Vol. 9, no. 2, pp. 91-100

BILD Publications, 1996

Robinson, R. & Le Grand, J. (1993)

"Evaluating the NHS Reforms"

London: King's Fund Institute

Robson, C. (1993)

"Real World Research: A Resource for Social Scientists and Practitioner Researchers"

Oxford, Blackwell

Rummery, K. (1998)

"Changes in Primary Health Care Policy: the implications for joint commissioning with social services"

Health & Social Care in the Community

Vol. 6, part 6, pp. 429-427

Ryan, J. with Thomas, F. (1987)

"The Politics of Mental Handicap" (Revised edition)

London: Free Association Books

Sabatier, P. & Mazmanian, D. (1979)

"The Conditions of Effective Implementation: a guide to accomplishing policy objectives"

Policy Analysis, 5, Fall 1979, pp. 481-504

- Shakespeare, T. (2000)
 "The Social Relations of Care"
in Lewis, G., Gewirtz, S. & Clarke, J. (eds.) "Rethinking Social Policy"
 London: Sage (in association with The Open University)
- Shaw, I. (1994)
 "Evaluating Interprofessional Training"
 Aldershot: Avebury
- Shepherd, G. (1990)
 "Community Care: A Historical Overview"
in Sharkey, S. & Barns, S. (eds.) "Community Care: People Leaving Long-stay Hospitals"
 London: Routledge
- Singh, P. (1995)
 "Community Care: Britain's Other Lottery"
 Mencap National Centre: Campaigns Department
- Smith, J. (1993)
 "Evolving Issues in Qualitative Psychology"
in Richardson, T. "Handbook of Qualitative Research Methods"
 Leicester: BPS Books
- Smith, S. & Lipsky, M. (1993)
 "Nonprofits for Hire: The Welfare State in the Age of Contracting"
 Cambridge, Massachusetts: Harvard University Press
- Srivastava, A. & Cooke, Z. (1999)
 "Changes in Quality of Life of People with Learning Disabilities Six Months After Transfer
 from Long-Stay Hospital into the Community"
 Tizard Learning Disability Review
 Vol. 4, issue 3, July 1999
- Swingewood, A. (1991)
 "A Short History of Sociological Thought" (2nd edition)
 Basingstoke: Macmillan

Symonds, A. & Kelly, A. (1998)

"The Social Construction of Community Care"

Basingstoke: Macmillan

Thane, P. (1982)

"The Foundations of the Welfare State"

London: Longman

Thistlethwaite, P. (ed.) (1998)

"Finding Common Cause? Impressions of links between G.P. fundholders and five social services departments in England"

London: Association of County Councils & NHS Confederation

Titterton, M. (ed.) (1994)

"Caring for People in the Community - The New Welfare"

London: Jessica Kingsley

Tizard, J. (1960)

"Residential Care of Mentally Handicapped Children"

British Medical Journal

Vol. 1, pp. 1041-1043

Tizard, J. (1964)

"Community Services for the Mentally Handicapped"

London: Oxford University Press

Todd, S. & Shearn, J. (1996)

"Time and the Person: the impact of support services on the lives of parents of adults with learning disabilities"

Journal of Intellectual Disability Research

Vol. 9, part 1, pp. 17-30

Todd, S., Felce, D., Beyer, S., Shearn, J., Perry, J. & Kilsby, M. (2000)

"Strategic Planning and Progress Under the All Wales Strategy: Reflecting the Perceptions of Stakeholders"

Journal of Intellectual Disability Research

Vol. 44, part 1, pp.31-44

- Towell, D. & Beardshaw, V. (1991)
 "Enabling Community Integration: the role of public authorities in promoting an ordinary life for people with learning disabilities in the 1990s"
 London: Kings Fund Institute
- Turner, S., Sweeney, D. & Hayes, L. (1995)
 "Developments in Community Care for Adults with Learning Disabilities: a review of 1993/4 Community Care Plans
 London: HMSO/Hester Adrian Research Centre
- Tyne, A. (1982)
 "Community Care and Mentally Handicapped People"
 in Walker, A. (ed.) "Community Care: The Family, The State and Social Policy"
 London: Blackwell & Robertson
- Walker, A. (1993)
 "Community Care Policy: From Consensus to Conflict"
 in Bornat, J., Pereira, C., Pilgrim, D. & Williams, F. (eds) "Community Care: A Reader"
 Basingstoke: Macmillan
- Waterson, J. (1999)
 "Redefining community care social work: needs or risks led?"
 Health & Social Care in the Community
 Vol. 7, part 4, pp. 276-279
- Webb, A. & Wistow, G. (1983)
 "Public Expenditure and Policy Implementation: The Case of Community Care"
 Public Administration
 Vol. 61, part 1, pp. 21-44
- Webb, A. & Wistow, G. (1982)
 "Whither State Welfare? Policy and implementation in the personal social services, 1979-1980"
 London: Royal Institute of Public Administration
- Wells, J. (1997)
 "Priorities, `Street Level Bureaucracy` and the Community Mental Health Team"
 Health and Social Care in the Community
 Vol. 5, part 5, pp. 333-342

Willot, S. & Griffin, C. (1997)

"Wham, Bam, Am I a Man? Unemployed Men Talk About Masculinities"

Feminism and Psychology

Vol. 7, pp. 107-128

Wing, L. (1989)

"Hospital Closure and the Resettlement of Residents"

Aldershot: Avebury

Whitehead, M. (1993)

"Is It Fair? Evaluating the Equity Implications of the NHS Reforms"

in Robinson, R. & Le Grand, J. (eds.) "Evaluating the NHS Reforms"

London: Kings Fund Institute

Wistow, G. (1994)

"Community Care Futures: Inter-agency relationships - stability or continuing change?"

in Titterton, M. (ed.) "Caring for People in the Community - The New Welfare"

London, Jessica Kingsley

Wistow, G. (1995)

"Aspirations and Realities: Community Care at the Crossroads"

Health & Social Care in the Community

Vol. 3, part 4, pp. 227-240

Wistow, G. & Brooks, T. (eds.) (1988)

"Joint Planning and Joint Management"

London: Royal Institute of Public Administration

Wistow, G. & Fuller, S. (1983)

"Joint Planning in Perspective"

Birmingham: NAHA

Wistow, G. & Hardy, B. (1986)

"Transferring Care: Can Financial Incentives Work?"

in Harrison, A. & Gretton, J. (eds.) "Health Care UK 1986"

Hermitage Policy Journals

Wistow, G., Knapp, M., Hardy, B., Forder, J., Kendall, J. & Manning, R. (1996)
"Social Care Markets: Progress and Prospects"
Buckingham: Open University Press

Wolfensberger, W. (1972)
"The Principle of Normalisation in Human Services"
Toronto: National Institute of Mental Retardation

Wright, K. & Haycox, A. (1991)
"Economics and the Care of People with a Mental Handicap"
in Baldwin, S. & Hattersley, J. (eds.) "Mental Handicap: Social Science Perspectives"

Wright, K., Haycox, A. & Leedham, I. (1994)
"Evaluating Community Care: Services for People with Learning Disabilities"
Buckingham: Open University Press

Appendix I

Interview schedules

General interview questions

(Indentations indicate subsidiary question or prompts)

How long have you been working in this geographical area, and with this client group?

How would you describe current working relations between the local health service and local social services?

In the time that you have been working here, how do you think that relations between the services have changed?

Are these changes for the better?

Did change come about largely as the result of local or national factors?

What factors have been of greatest importance in determining the state of relations between health and social services?

Did the NHS & Community Care Act make it easier to clarify the distinction between a health care need and a social care need for people with learning disabilities?

Were there any ways in which this piece of legislation helped to improve or worsen relations between health and social services?

Have you ever experienced difficulties at work which you feel were caused, or accentuated, by difficulties in achieving effective co-operation between local health and social care services?

Give examples.

Are you aware of any disagreements arising locally over the definitions of health care needs and social care needs?

Give examples.

Are you aware of formal written agreements between health and social services which specify what constitutes a health care need and what constitutes a social care need?

Yes?: who drew up these guidelines and who interprets them in the context of disputes

No?: are you aware of any plans to develop such guidelines and how are disputes of this nature currently resolved

If conflict does occur between health and social services, at what level in the organisations is it most likely to occur?

What issues are most likely to cause conflict between health and social services?

e.g. financial; practical; ideological; personal

How does this affect the delivery of services?

How has social services becoming 'lead agency' for adults with learning disabilities affected services locally?

Do you feel that social services give people with learning disabilities a high enough priority, compared to that given to other client groups?

How does this compare with the degree of priority given to people with learning disabilities within health services?

Are local services for adults with learning disabilities 'needs-led' in any meaningful way?

Give examples of practice

What means, if any, do you currently have for assessing how much unmet need for services exists within the learning disabled population?

Is the overall level of unmet need rising or falling?

Are there any particular types of services which are needed but which are not currently available locally?

How much, if any, crossover of staff occurs locally between health and social services?

Is this useful/helpful?

Should it be encouraged/discouraged?

How would you describe the management style and organisational culture within your service?

How does this compare to that within social services/the health service (as appropriate)?

How well do you feel that you know the structure of your own organisation and that of social services/the health service?

e.g. Lines of accountability; knowing who to go to with a problem

Do you feel that organisational structures or the personal attributes of those working within an organisation are of greatest importance when attempting to foster co-operation between organisations?

Why.....?

What changes, if any, would you like to see in working practice to improve the quality of local services?

Are there any changes in legislation which you would like to see introduced by central government?

Do you think that current moves towards Primary Care Groups in the health service and Best Value in social services offer a hopeful future for learning disability services?

Questions specific to managerial staff

If/when disagreements concerning the boundaries of health and social care arise, how are these disputes settled?

Do you have formal written guidelines which define health care needs and social care needs?

Has local protocol developed so that disputes of this nature can be dealt with consistently?

If disputes arise over financial do they usually centre on the funding of individual care packages or do you tend to negotiate over principles which can then be applied to all relevant situations?

Will pooled budgets bring an end to wranglings over finance or simply change the nature of the argument?

Are disputes of this nature confined to the senior management team or are all levels of staff involved?

How do you feel that financial or other management disputes affect staff lower down the organisational hierarchy?

Are there enough private and/or voluntary sector service providers to create an effective market locally?

Questions specific to CLDT workers

Generally speaking, how would you depict inter-professional relations within this CLDT?

Within your CLDT how does the role of the social worker differ from that of the community nurse?

e.g. types of client worked with; nature of the work undertaken

How are decisions made as to whether an individual will receive social work or community nurse support?

Do some clients receive input simultaneously from a social worker and a community nurse?

To what extent are the roles of social worker and community nurse interchangeable?

How much professional autonomy are you given as a social worker/community nurse?

How does this compare to the autonomy given to community nurses/social workers?

Questions specific to consultants

Have consultants in the field of learning disability gained or lost influence, in determining patterns of service provision, since the implementation of the Community Care Act?

How, if at all, has the introduction of professional managers into NHS services changed the nature or direction of local health service provision?

How, if at all, are consultants in this area involved in service planning?

What role, if any, have consultants played in negotiating health and social care boundaries?

At the level of inter-service agreements?

At the level of disputes over funding individual cases?

Have health services locally moved away from the traditional 'medical model' of care for people with learning disabilities towards a 'social model' since the introduction of the Community Care Act?

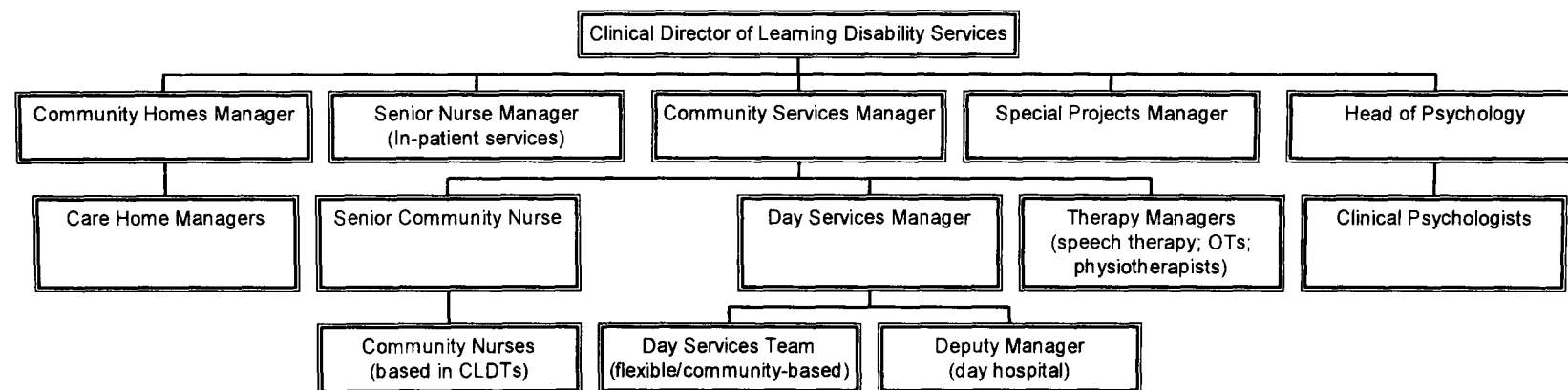
Are the needs of people with learning disabilities afforded a high enough priority by GPs and other primary health care professionals?

What effect, if any, did the NHS reforms of the 1990s have on relations between learning disability consultants and GPs?

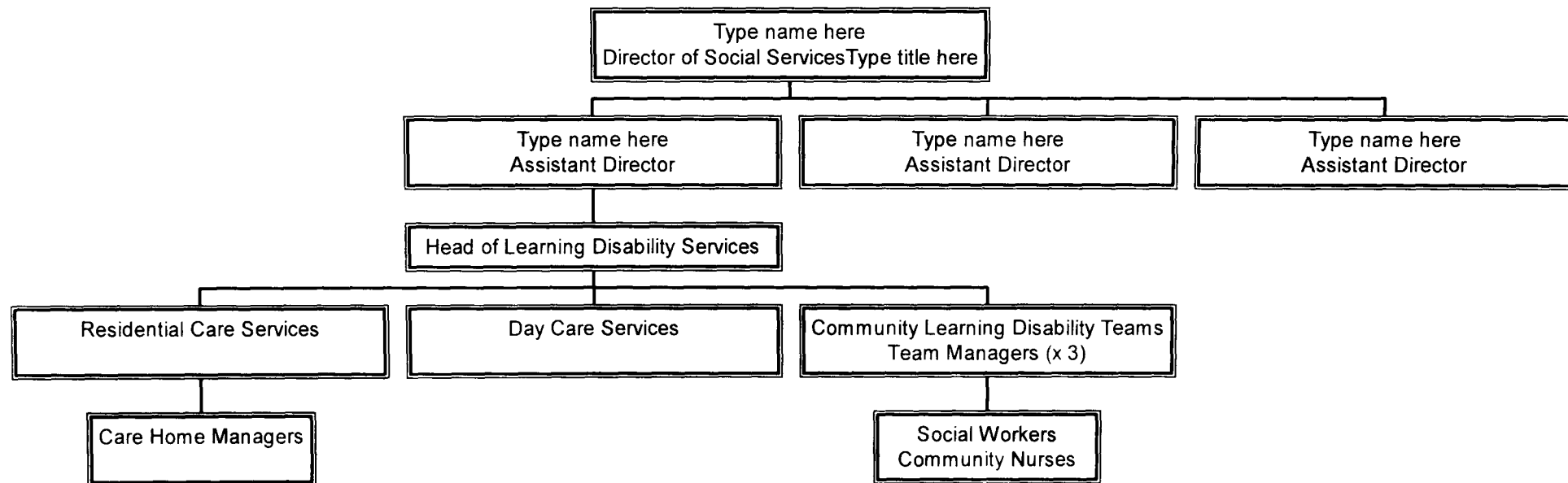
Appendix II

Organisational flow charts

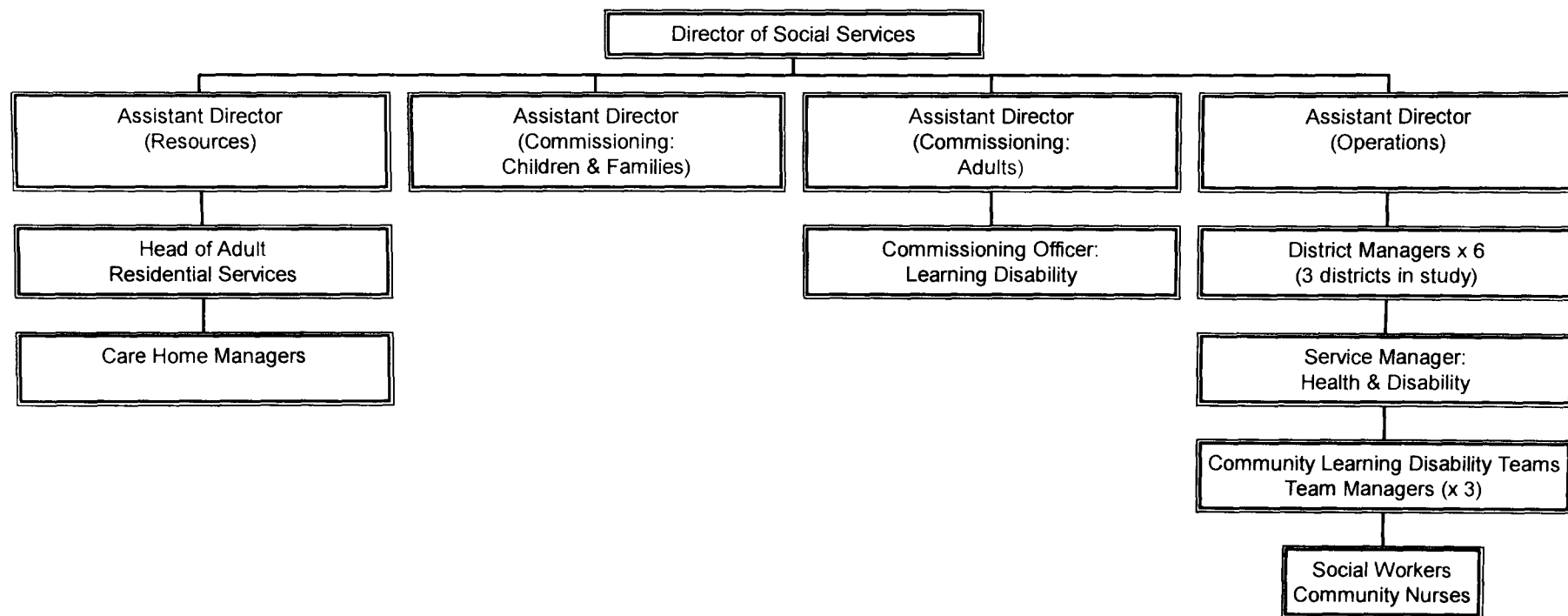
Appendix II, figure 1
Health Services – area A



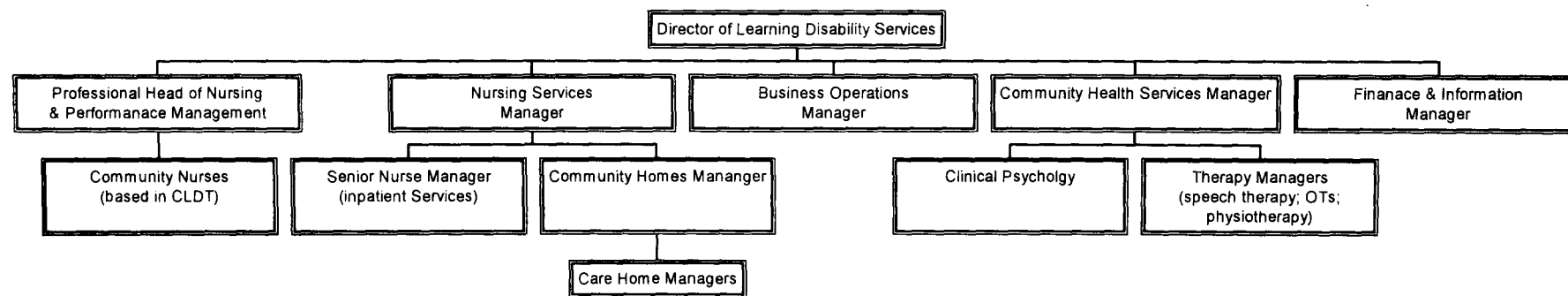
Appendix II, figure 2
City Social Services – area A



Appendix II, figure 3
County Social Services –area A



Appendix II, figure 4
Health Services – area B



Appendix II, figure 5
Social Services – area B

