Developing social care:
the current position

Chapter 3: Social care-related partnership processes

Conceptualisation and approach

While most of this report addresses evidence on specific client groups, this chapter examines some overarching themes concerning partnership – referring to joint working, coordination, collaboration, and integration activities – in and around social care. (The qualifier 'and around' is intended to refer to the blurred boundaries with social support, health care, social housing, and community development. Below, we abbreviate this to 'social care related partnership'.) It draws on a wide range of papers, both client-group specific and generic, which address these topics directly and indirectly. Regrettably, only a few papers reach clear conclusions on the impact of these factors on users' well being (Quilgars 1997; Cooke *et al* 2002; Kharicha *et al* 2004; Payne *et al* 2002; Glendinning *et al* 1998; Glendinning 2003; Cameron *et al* 2000[1]). For most, the methods tend to preclude drawing such conclusions, either because it is difficult to aggregate the data or because users' views were not sought in the first place. This limitation seems to be shared with the literature on 'partnership' in other fields of social policy (Sullivan and Skelcher 2002; Glendinning *et al* 2002).

This chapter also diverges from the use of the production of welfare approach found in the remainder of the report. The processes of integration, partnership and collaboration require a different approach. This can be expressed in diagrammatic form, situating 'production' in its wider environment. Figure 3.1 underlines the disparity between the productive capacity of the market for social care and conventional markets, arising from the fact that the former is heavily affected by the public sector. This includes both local authorities, with their wide range of legal responsibilities in this field, and central government, with its many regulation, inspection and resourcing activities. The evolving relationships between these public sector bodies shape the meso- and macro-level contexts in which care services are delivered.

It is important to recognise that these external linkages contribute to the functioning of local systems in much the same way as internal ones, for instance between users, care staff, owners and managers. The nature of these arrangements is crucial to their supply, because the providers of social care tend to be motivated not only by business objectives or the 'internal' rewards of meeting user needs behind closed doors. They are also concerned to achieve recognition for their professionalism and the right balance between respect for their autonomy and support via monitoring and control.

---

[1] The Cameron *et al* reference still being traced at the time of writing, but presented in Glendinning as a central source for understanding the inconclusiveness of research on joint working in health and social care: it is Cameron, A, Lart, R, Harrison, L, Macdonald, G and Smith, R 'Factors promoting and obstacles hindering joint working, A Systematic review', Bristol School of Policy Studies, 2000.

Both internal and external networks can be seen as repositories of *social capital*, that is they tend to add value through the generation of trust, receptivity and shared understandings. This social capital can be viewed as a 'factor input', like other forms of capital, but it is qualitatively different in that it inheres in relationships *between* actors. The figure emphasises this 'non market' aspect by situating social capital in the lower half of the diagram, whereas other factor inputs are visibly traded. Lying behind this production, in 'production of welfare' terms, are the 'non resource inputs' which affect production, including the care environment, staff attitudes and client characteristics (Davies and Knapp 1981; Knapp 1984). Social capital is significantly shaped by the character of the local contracting context, and is generated by human interaction.

Social care policy options are shaped by both inherited arrangements and new policy initiatives. Official documents tend to concentrate on the latter, as can be seen in the emphasis of recent Social Services Inspectorate (SSI) annual reports on performance management, or the focus of Joint Reviews on 'the new virtues'. Some important ingredients have a much longer pedigree, however, such as the purchaser-provider split or even older initiatives, including the SSA settlement institutions, the central government special and specific grants system, local level inter- and intra-departmental allocations, and decisions on local taxation rates (including council tax). These are all part of the national macro context.[2] So, too are policy guidelines, circulars and reports emanating from the Department of Health, SSI and Audit Commission.

Nonetheless, the pace of reform under the current government is notable. Health care reforms have dramatically spilt over into the social care domain, creating a massive 'grey' area between health and social care (Lewis 2001; Glasby and Littlechild 2000). An early wave of macro-level policies influenced supply through the encouragement of partnership and flexibility in local authority-NHS relations following the 1999 Health Act; the push for 'standards' and more recently 'fair access'; national implementation of generic Best Value policy for local government responsibilities; national social exclusion policy; and national employment policy, including the minimum wage and the working time directive legislation.[3]

---

[2] Decisions regarding how to distribute funds *between* client groups are part of this process. Traditionally, not only have specific and special grants from central government tended disproportionately to favour services for client groups other than older people (in the sense that such grants account for a much higher proportion of social care expenditures on those client groups), but local authorities have on average underspent on older people's services relative to central government's 'indicative' allocations (cf. Royal Commission 1998; Laing & Buisson 2000).

3 Employment policy has also been tailored specifically to social care. The 1998 White Paper *Modernising Social Services* (chapter 5) proposed development policies specifically focused on the social care workforce for the first time (see Matosevic *et al* 2001, for a comprehensive mapping; more recently, see the TOPPS intelligence reports). The General Social Care Council and the Training Organisation for Personal Social Services will seek in the future to widen training opportunities and increase levels of qualification, with knock-on effects for social care labour markets, and thus for residential care supply.

Since 2000, against the wider backdrop of the NHS Plan and the adoption of some recommendations from the Royal Commission on the Future of Long Term Care (1999), a second wave of macro policy initiatives built on the inherited structures and the first wave of change. There is a complex layering of pre-1997 arrangements, reform, and consolidating initiatives, both tactical and strategic. In 2001, for example, the Government added to the plethora of existing measures for partnership by announcing an agreement to promote 'partnership' specifically to avert a crisis in residential care.[4] This proceeded alongside more strategic measures, made possible in part by the 2001 Health and Social Care Act, but including the implementation of approaches from earlier legislation. For example, the national service frameworks, associated performance assessment frameworks, the Commission for Social Care Inspection (CSCI), and national minimum standards have been put in place only relatively recently. Finally, both the macroeconomic climate and general economic policies, of course, play a part in influencing social care.

---

[4] This included action checklists for stakeholders in care demand and supply, and announced a new cash injection of £300 million to those local authorities where it perceived residential care supply and bed blocking problems to be most severe (Department of Health 2001b; *Community Care Market News* October 2001).

The view from the SSI/joint reviews

It is instructive to examine some official accounts, because they embody the main priorities of central policy makers and illustrate their perspective on the progress of implementation. We therefore summarise two recent overviews: the Audit Commission/SSI review of joint reviews, and the SSI Chief Inspector's assessment of the overall direction of change in social services. (The SSI has recently been merged with the National Care Standards Commission to create the 'Commission for Social Care Inspection' referred to above.)

The *Old Virtues, New Virtues* report (SSI/Audit Commission 2004) reviews annual reports and other evidence since 1996 and sets out the overall picture in terms of users' views, changes in services and changes in organisation. Regarding *users*, it is claimed to be 'indisputable' that choice has been extended by the provision of a 'wider range of services' (although those users who do not meet tightened eligibility criteria are excluded; and see our discussion of choice in chapter 4, for example). Users are reported to be more involved in shaping services, although this is not quantified. Through an analysis of attitude surveys over time, an upward trend is reported in the proportion of respondents indicating that they received 'all the help they thought they needed'. Levels of satisfaction have remained steady: on average, 70% of respondents (50,000 surveyed over the total period) indicated that their services were 'excellent' or 'good'. Much of the survey evidence, however, is more troubling. Trends in complaints are mixed or negative. There has been a striking decline in those who receive help quickly (within a day of contact) from 15% to 8%, and low but improving levels of access to information prior to receiving help (28% in 2003, up from 23% in 1996). There is also an unquantified, but apparently marked, decline in the number of users who report appropriate continuity of care.

With respect to *changes in services*, much of the discussion is client-group specific, but five 'main directions' span client groups, although subject to local variation (see also Knapp *et al* 2001): 'institutional' to 'community based' provision; 'administering' care to 'supporting independence'; towards 'greater diversity of service providers'; 'more organised matching of needs and priorities to services'; and 'better co-ordination across health, education and housing'. There is an implication that national bodies should be given the credit for steering and stimulating these trends: 'most change has been noted in areas that have been given the status of national priority, subject to national performance assessment, and in some cases that have been given special monies to develop' (p.17).

Finally, it is argued that there has been a 'marked shift' with respect to *changes in organisation.* Relevant characteristics include complexity, wide scope, and 'integration', as well as some of the service features mentioned above. The 'tasks' are said to have

become more challenging, but the capacity to fulfil these tasks affected by the (dominance of) the language of managerialism, business planning, performance targets, Best Value and modern technology. The new style is presented as having certain key features, including greater use of the independent sector via external commissioning, compared to the provision of in-house services, and an emphasis on 'consistency assured by performance management', seen as more progressive than 'individual professional duty'.

A review of the headlines from recent SSI annual reports also provides a complementary perspective on the view from the top of the specialist social care policy community. There is much in common with the Joint Review overview, but three differences in emphasis are apparent (SSI Inspectorate, 2000/2001 – 2002/2003). First, the overall tone is more cautious, with more extensive references to problems, constraints and 'slowness' in implementing desired aspects of 'modernisation'. Second, a richer set of drivers and influences are discussed, with less weight given to national impetus, and more to the positive role of local actors. Third, professionalism is explored in a more rounded way, with care taken *not* to conflate this with management priorities. Despite heavy emphasis on the new performance assessment system and council ratings, some attempt is also made to report on the system's functioning beyond 'management performance'. There is also acknowledgement of workforce problems, with a recognition of the close connection between the quality of care and the quality of staff providing that care.

Social care-related 'partnership' as a learning/ informational process

Changes in policy and practice derive from a combination of political decisions, external shocks, and 'policy learning' (Sabatier and Jenkins Smith 1993). What does the literature tell us about such processes in the case of social care partnership?

National policies outlined in earlier sections explicitly address learning by professionals: the various frameworks for priority setting seek to embed and reproduce best practice, not least through comparison and benchmarking. A range of initiatives has sought to encourage the dissemination of information on social care and to encourage a general shift towards 'evidence-based policy'. The establishment of SCIE – and the DH-sponsored research that preceded it – have been central to this process (Sheldon *et al* 2003; Swinkels *et al* 2002). New programmes are reforming curricula and career opportunities for nurses and social workers. Efforts are also being made to develop vocational training and knowledge transfer around key categories of worker involved in social care (cf. the national training organisations, workforce confederations, and allied institutions relating to nurses and the social care workforce) (Masterton 2001). Moreover, information technology systems capable of meeting the joint needs of health care, social care, and integrated care systems are being designed and implemented (Godden and Pollock 1998).

Between the institutions for the acquisition of practical skills and efforts to steer the national research effort can be found joint local authority-health authority research activities (Cooke *et al* 2002). There are also evaluative components within national policy initiatives, many of which touch on social care and its interface with the health service, such as the Health Action Zones. Increasingly, such partnerships are required to build in 'realistic' and 'inclusive' learning components, embracing a wide range of stakeholders, in order to justify financial support (Sullivan and Skelcher 2002; Judge and Bauld 2004).

The academic literature broadly welcomes the thrust of these developments and points to some encouraging breakthroughs, but also notes a range of barriers which have significantly constrained the capacity of systems – and the individuals within them – to reach their potential. The consolidation and utilisation of multi-disciplinary databases for clients using multiple services are seen to hold much promise for health and social care (Keene *et al* 2001). Yet poor quality record keeping and problems arising from incompatible systems are still evident, severely hampering the smooth processing of client information and causing anxiety among users and professionals alike (Glasby and Littlechild 2000; Godden and Pollock 1998, 2001). Problems of information exchange between health and social care professionals are exacerbated by cultural and epistemological barriers (see section 3.4), including different ways of logging and

aggregating data. Comparable problems have also been reported at the interface between social care and housing, where information exchange is routinely hampered due to 'confidentiality' constraints[5], although some researchers have argued that this is often simply a convenient excuse not to co-operate (Secker and Hill 2001). Even where data has been assembled, however, huge volumes tend to be abandoned because of overload and system incompatibilities (Ford and Simic 2001; Lund and Ford 1997).

The solution typically put forward in official policy documents – allocating responsibility for resolving these issues to a named key worker – is likely to help only under certain conditions. These include supportive coordination systems, adequate resourcing, and exceptional skills, since the broker must 'be able to transcend a particular professional identity or organisational affiliation' to work effectively (Payne *et al* 2002). Community workers have long pointed to the formidable task of dealing even with a single agency, arising from poor internal distribution of basic information about procedures and entitlements and sometimes obstruction and deliberate misinformation (Combs and Sedgewick 2000). Dealing with multiple agencies can be assumed to be much more complex (Victor *et al* 1993).

Research also reveals problems of information flow and absorption in most other domains in which practical learning is meant to occur. There is, first, the major challenge of applying theoretical knowledge to practice. Analysts have traditionally pointed to the difficulties experienced by trained social workers in accepting the legitimacy of evidence perceived to be based on inappropriate methods or to pose a threat to professional 'artistry'. Although this may be a genuine issue, it can be overstated: according to recent surveys, the most important barriers to learning from research are lack of time and resources. Social care and integrated service professions still compare poorly to health care professions in terms of access to training, libraries, and internet based resources. The demands of compliance with performance assessment systems and related workplace pressures also take their toll, so that professional learning is often done at home (Swinkels *et al* 2002; Sheldon *et al* 2003). On the other hand, inter-agency research, facilitated by NHS primary care research networks, has been found to offer valuable opportunities for skills acquisition, and enthusiastic individuals have found ways to conduct studies. Immediate local service improvement has tended to drive out efforts to acquire generalisable knowledge, however, and social service departments have often provided little or no encouragement, so that arrangements have tended to be fragmented and ad hoc (Cooke *et al* 2002).

To what extent have lessons from research and practice been accepted by decision makers in the field of social care? Traditionally, the latter were thought to be

---

[5] Secretiveness has also been particularly associated with over-reliance on market-style arrangements in the early 1990s; see Wistow and Hardy 1999.

unresponsive to research messages, whether emanating from practitioners or from academia, where these were in conflict with what they wished to hear, particularly in relation to costs (Lewis and Glennerster 1996; Means and Smith 1998). The position may have changed subtly, however, with policy makers more open to research findings, as shown by the investment in many relatively long-term collaborative community-based experiments (Sullivan and Skelcher 2002).

Some contend, however, that the government has increasingly become *selectively* deaf, readily absorbing evidence compatible with its focus on short-term results and rejecting other evidence without serious explanation. The consequent interventions seem to involve high degrees of centralisation, potentially demoralising and de-motivating local professionals. Health Action Zones, for example, although widely welcomed for their progressive theoretical frameworks, suffered budgetary cuts, were given insufficient time to evolve and, from the perspective of those involved, were arbitrarily forced into national measurement straightjackets (Barnes and Sullivan 2002; Judge 2004). There have also been difficulties the genesis of the 'care trusts' proposal, although there is less research consensus in defence of the *status quo ante* in this case. Some leading analysts argue that the more voluntaristic approach to the design of institutions for integrated care has proceeded at a reasonable pace and should be left to continue to evolve with a high degree of autonomy (Hudson 2002; Hudson, undated, and references therein). Network-based governance can be relied upon to facilitate learning and hence policy change (Hudson and Hardy 2001; Mur-Veeman *et al* 2003). Others have suggested, in contrast, that there is a strong case for higher levels of compulsion to counter inertia and resistance in some areas, although this view is often coupled with a concern to avoid any further concentration of power in the hands of central government (e.g. Johnson *et al* 2003).

Prominent critiques have come from the voluntary sector, as well as from academic commentators. In theory, the government is now more receptive than ever to these arguments. (While central government has always relied on voluntary organisations for intelligence and advice, it is only the present government which has put the sector in the 'mainstream'. See Kendall 2000.) Drawing on research on organisations for older people, as well as more general social care developments, three themes, suggesting significantly differences in priorities, are worth highlighting. First, there is a debate over the overall gearing of the system towards discrete acute hospital-based interventions on the one hand, and preventive, more holistic, forms of care and support on the other. The government has redistributed some of its allocation of policy effort and resources towards the latter, including a variety of centrally funded 'partnership' configurations, commitments to public health measures, and efforts to build in such priorities to new guidance instruments (such as the national service frameworks and performance assessment frameworks).

However, many leading organisations in the voluntary sector have claimed that these efforts have been too piecemeal and the resources insufficient, given the magnitude of the task. They have also questioned the ability of guidance instruments to 'deliver' when competing with powerful medical priorities. (Clear examples are the critiques and commentaries of Help the Aged and Age Concern England on care for older people.) How can this be the case, if the state is supposedly more receptive to its concerns? Voluntary organisations no longer bemoan a lack of consultation per se - indeed, many complain of 'initiativitis' - but now argue that processes have been *insufficiently inclusive*, and their views *insufficiently accommodated* in substantive resource allocation decisions (Wyatt 2002). Academics have highlighted the extent to which voluntary organisations favour more holistic approaches than revealed in actual policy or practice, arguing that the to a large degree, this is because the state itself is configured in the 'vertical' silos of both Departmental and traditional medical professional interests (Newman 2001; Clarke and Glendinning 2002; Glendinning *et al* 2003).

There is also a pressing issue regarding the structural position of the voluntary sector *itself* in the social care system. The voluntary sector performs a range of socio-political functions in all major policy fields, but is particularly prominent in social care. Among its contributions to the system's ability to learn are its role as pioneer, innovator and exemplar. Yet, despite government rhetoric, its ability to discharge these functions may have been increasingly constrained in recent years, according to a recent review of expert opinion. The extent to which this is due to policies inherited from the previous government (such as the orientation towards contracts and markets) or policy developments since 1997 (such as the introduction of national service frameworks and performance measures) is a matter of keen debate.

The materials reviewed in Kendall (2003) also raise concern about the sector's capacity to fulfil an *expressive* function. This is not directly related to system learning *per se*, because the activities are not intended to lead to service developments or innovation, but voluntary organisations have long argued that specific low-level interventions are important to allow social care clients to thrive. They have also been prominent in claiming that personal development requires an environment in which care workers not only discharge discrete care tasks but can get to know users. It is felt that both user and worker can be enriched by spending relaxed time together, telling stories, and relating personal histories. Volunteers, concentrated primarily in voluntary organisations, are seen to have a comparative advantage over paid carers in certain circumstances (cf Quilgars 1997). As discussed in later chapters, some recent work on user outcomes has 'validated' this account on a more 'scientific' basis. The key point here is that the heavily task-specific environment which has evolved as public authorities seek to focus resources on the most dependent individuals – and as management requires providers to demonstrate this prioritisation – can then be counterproductive.

What are we to make of these debates? While voluntary sector organisations' arguments are typically passionate, well argued and thus convincing, their claims tend to be based on individual case studies and experiential knowledge, as there is no corpus of quantitative research on which to draw. For example, in her systematic review of 'low intensity' care and support, including many activities traditionally favoured by voluntary organisations[6], Quilgars identified roughly 5000 published papers, but found researchers rarely attended to user outcomes. There were only two RCTs, and only 41 studies which otherwise met her criteria of rigour, including well designed qualitative research (Quilgars 1997; see also the references in Kendall 2003). Depending on the meaning attached to 'evidence-based policy', one would reach very different conclusions. It could be argued that there is insufficient research to substantiate any claims (a view likely to be supported by those who cleave to strictly positivist social science epistemology); or, if the marshalling of experiential knowledge and a mass of case study materials is taken to represent a credible evidence base, then many of the voluntary sector's critiques would need to treated as deeply worrisome.

---

[6] In scope for this review were direct practical support (such as housework and tasks traditionally performed by home helps), housing/tenancy support, and emotional/ social support (such as befriending schemes).

Social care related 'partnership' as an inter-professional / cultural process

Despite widespread interest in the idea of service integration, there is little consensus about what it means in practice. It can refer to autonomous professionals exchanging views and information; fully or partly co-located *multi*-disciplinary joint and team working; *inter*-disciplinary collaboration across organisational boundaries and structures; or shared governance structures and joint control of human and financial resource decision making (Kharicha *et al* 2004).

Researchers have yet to develop a consensus on precisely when each of these different configurations are appropriate, in terms of either client group or forms of care. But most agree that inter-professional collaboration does have an important role in supplementing other forms of collaboration. Perhaps the greatest precision that can be suggested, given current knowledge, is that this form of co-operation, supported by extensive structural integration, is particularly appropriate when needs are especially complex and unpredictable (Johnson *et al* 2003). Under these conditions, 'lighter' arrangements for co-operation, such as multi-disciplinary based case management, may not be fit for purpose (Kodner 2004). It is also widely agreed that service professionals must be committed for efforts to integrate services to work (Masterton 2001; Ferlie 199X cited in Leutz 1999).

If some form of joint working at the interface between social care and other public services is essential to address users' complex needs, what do we know about its contours and possibilities? The main message from research is that it tends to be a difficult, contested and frustrating process. It is an enduring theme that appropriate service development at the interface between social care and other public services is blocked or undermined by tensions between some of the main professionals, as carriers of competing and contradictory social and health care cultures. Social workers, nurses, general practitioners and higher status health professionals (such as hospital consultants) feature most prominently in research accounts. Strongly influenced by the pioneering work of Huntington, analysts have theorised the situation in terms of inherent epistemological incompatibilities, and concomitant tribalism, defensiveness, and mutual suspicion, expressed in concrete relationships and practices (Manthorpe and Iliffe 2003). Similar difficulties have also been noted with other professional groups, such as health visitors and occupational therapists, as well as housing and community development professionals (Ford and Simic 2001 Taylor 2003; Barr *et al* 2001; SOLNUN 2003).

At a strategic level, a number of historical analyses have examined the ways in which the different world views and *modus operandi* of health and social care professionals undermined the joint planning and consultation arrangements evolved between the late

1970s and the mid 1990s. These cultural gaps between professions were reinforced by different organisational planning cycles, accountability arrangements, decision making processes and funding structures, in part reflecting the concentration of most social care professionals within local government and the concentration of most social care-related health care professionals within the NHS, and hence linked more closely to central government level (Lewis 2001; Mur-Veeman *et al* 2003; Hudson and Henwood 2002).

The 1995 continuing health care guidance sought to explicate how care responsibilities could be appropriately allocated in this difficult context. Its implementation proved to be problematic, however. A study of continuing health care policies in three NHS regions, based on interviews and focus groups with both policy and front line staff, catalogued a range of difficulties. These included a failure to develop an appropriate level of detail in eligibility criteria; a complete absence of guidance for some relevant services; and a paucity of protocols, although specifically required in the Guidance (Abbott and Lewis 2002 p.536). Those leading policy felt themselves caught up in intractable problems because prior strategic agreement had been reached by fudging and ambiguity. Front-line workers had welcomed the idea of clear guidance, but were disappointed when they found a lack of leadership and clarity. They felt that they bore the brunt of persistent vagueness, routinely encountering the 'devils in the detail' when they tried to operationalise the guidance in practice. Even where both principles and the details of implementation were clear on paper, they felt the system was undermined by the tendency of both GPs and consultants to take 'little of no notice of the criteria' (*op cit*, p.537). A climate of resource austerity meant that professionals tended to be defensive and suspicious in dealing with others from across the 'wall', for fear of 'cost shunting'. The problems had also been entrenched by the way in which previous reforms and financial responsibilities had played out.[7]

Much recent research work has focused on the social care-health interface at the level of primary care. A number of case studies explore social worker attachments to – and links with – GP practices, but these rarely consider the impact for users (Glendinning *et*

---

[7] In particular, social care professionals had to develop detailed and implementable local eligibility criteria in order to operationalise the dual financial and service rationing role demanded of them by case management. However, there were no such pressures for coherence and practical principles on the part of health services, with their fragmented, loosely coupled and internally oppositional interests. GPs and consultants, indeed, had avoided being drawn into the criteria setting process at all, which would have been experienced as a constraint on prized autonomy (*op cit* p.539). Continuing to protect their decision making space from 'external interference' gave them both the incentive to avoid engagement with this process in the first place and helps to explain their negative attitude towards the criteria as developed.

al 1998; Glendinning 2003[8]; Kharicha *et al* 2004). For example, a study in two health authorities notes the deterioration of relationships between primary health care and social workers, cataloguing 'deep-rooted prejudices' and 'poor personal relationships' (Hiscock and Pearson 1999 p.155). Other studies have emphasised the development of alliances *across* health and social care, for instance between nurses and social workers. Nonetheless, difficulties arise from incompatible professional values and priorities as well as from a 'preoccupation with internal organisational issues'. Increasingly heavy workloads, adjusting to different demands from within their organisation and their own professions and heightened job insecurity were reported to generate great anxiety among both groups. Indeed, the researchers note that it was difficult to keep respondents focused on a discussion of external and inter-professional relationships, as they 'tended to answer very briefly and revert, unprompted, and at considerable length, to a discussion about issues within their own organisation' (p.156).

Since the introduction of primary care groups, and subsequently primary care trusts, researchers have examined whether inherited dysfunctions have been rectified. These large organisations are crucial actors at the health and social care interface and have been major beneficiaries of public health and preventive health and care monies made available by the Government in pursuance of its NSF and other priorities (Glendinning 2003 p.143). Their governance includes representation from social services in the shift towards integration. The general tenor of their report is cautious. The authors note that expectations for change must be realistic, given the longstanding nature of many problems. With respect to inter-professional working, for example, difficulties are accentuated by pressures arising from organisational and territorial boundaries. Yet 'positive impacts' on inter-professional relationships have been reported, in terms both of the governance of these bodies and their operational practices. For example, Coleman and Rummery (2003), from an examination of a 15% representative sample of PCG/Ts between 1999 and 2001, emphasise that social service representatives increasingly experience relations as 'mainly friendly or constructive'. Moreover, planned service developments, such as intermediate care, seem to reflect both social and health care priorities when set out on paper (see also Glendinning 2003 pp.142-5).

However, there are 'major limitations'. Doubts about the influence of social services are routinely expressed both by their representatives and by other board members. Significantly, echoing the implementation gaps noted in pre-PCG studies, a *deterioration* in ratings for operational collaboration is reported. Actual arrangements for delivering agreed goals, such as intermediate care, may on closer examination give greater weight to medically defined service options, rather than activities which fulfil an

---

[8] Glendinning references an important 'systematic review of factors promoting and obstacles hindering joint working' – listed as n [11] p. 151 of her health policy paper. Need to get this. Concluded there were 'only four studies which met the review's inclusion criteria and even these failed to provide conclusive evidence of the benefits to users of joint working' (p. 141).

'expressive' function or provide low intensity *social* services (to use the language already introduced in the context of our discussion of the voluntary sector in section 3.3). Returning to a familiar refrain, the attitudes and actions of 'independent minded' GPs are stressed as particularly difficult, with biased priorities in this direction. Finally, the functioning of PCTs is being undermined by the turbulent policy environment, coupled with fear of further reforms. These, it is argued, would further marginalize the contribution of social care professionals, whilst empowering medically oriented health professionals. This could happen particularly if the 'collegiality' that the new structures are meant to foster develops not along 'healthy' inter-professional lines, but uni-professionally between general practitioners (Hudson and Hardy 2001), to the exclusion of input from others.

These papers have all tended to reach pessimistic conclusions on the nature of inter-professional relationships arising from efforts to engage in 'partnership' and collaboration. The principal theoretical underpinnings for their argument stem from the work of Huntington in her 1981 study of social worker-GP relations (Huntington 1981). One might question whether these are still relevant 20 years later. In a thoughtful revisit of this work, Manthorpe and Illiffe (2003 p.86) note that her key point was that joint working in this domain involves gaps in 'status and prestige, knowledge, language, focus, orientation and time perspectives', constituting barriers to successful collaboration. Huntington had suggested that these barriers were not only unlikely to be overcome, but would become more visible following the Seebohm reforms, with their positive implications for the status of social workers; as a result, conflict and even crisis would ensue. They argue that in fact a more complex and less dramatic scenario has unfolded, not resolving these difficulties, but involving ongoing efforts from both sides to avoid or manage them. Moreover, there have been changes in the ability of both professions to project their favoured agendas. Dwindling public trust, together with the introduction of market mechanisms, has disempowered both sets of professionals and put them 'on the defensive'. Social workers have additionally been enfeebled by their situation as local authority employees, as this tier has become significantly weakened in the last two decades.

How has overt conflict been circumvented or defused? The same authors suggest that each set of professionals has basically avoided each other at most levels and in most respects. The sorts of collaborative efforts discussed by Glendinning, for example, have evolved on only a very limited scale when viewed against the health service as a whole, despite recent structural reforms. Second, the Huntington prediction of a demographic reinforcement of the inter-professional cleavage – an ageing health establishment against young radical social workers – has proved inaccurate: the average age of GPs has fallen, while many social workers are entering the profession later in life, and are less likely to be radically oriented. Third, in the quite limited range of situations when substantive relations have taken shape, they have tended to involved 'polite and generally positive efforts to find agreement and commonality'.

Similarly, Glendinning (2003) has argued that recent reforms have catalysed certain incremental adjustments, but against a backdrop of profound continuities which essentially contain, rather than resolve, professional tensions. From both her own study of primary care groups/trusts and collaborative research with Hudson on the Health Act flexibilities, she reaches a sanguine conclusion. The 'internal' reforms which these arrangements represent have generated some concrete gains, such as 'immediate (albeit initially marginal) shifts in traditional patterns of expenditure in the deployment of human and other resources; and…ways of thinking and conducting business, particularly among senior officers and managers' (p.148; elaborated on pp.148-149). At the same time, however, disabling uncertainties emerged as new systems bedded down, together with restraining pressures from professionals defending their 'domains'. Echoing her own and others' earlier work, she emphasises that both GPs and hospital consultants were particularly obstructive. These problems were compounded by having to deal with other 'unjoined up' departments and authorities, which increased the vulnerability of attempts to foster stability, together with inappropriately short consultation timetables. A lack of opportunities for users to contribute substantively, despite rhetoric to the contrary, were also diagnosed as 'fundamental flaws' undermining progress in addressing short term implementation problems (*op cit*, pp.149-150).

In sum, Manthorpe and Iliffe (2002) and Glendinning (2003) together paint an apparently more realistic and nuanced picture than that suggested earlier by Huntingdon. Adaptability and tactical ingenuity in the face of perceived external pressures across professional lines, coupled with senior officer and manager initiative, has allowed the system to muddle through with marginal change. Hudson (2002) has also challenged the sociological 'orthodoxy', distilling hypotheses from a wider group of authors, and moving beyond the particular case of GP-social worker relations (his main reference point in Carrier and Kendall 1995). He argues that there are three 'dominant features' of the 'pessimistic tradition'. These include the imperative of maintaining '*identity*', reflected in both formal theories and informal assumptions (especially likely to limit shared problem diagnoses and practical proposals); professional '*status*', whereby contrasting social standing and accountability patterns limit the meeting of minds; and differences in professional '*discretion and accountability*', resulting in differing expectations regarding the appropriate influence on resource allocation of professional norms on the one hand and bureaucratic system priorities on the other (*op cit*, pp.8-9). The author argues that his case studies of professional relationships between health and social care workers providing care for frail older people in three areas do not support this 'pessimistic model' (Callaghan and Hudson 2000; Hudson and Callaghan 2000). He suggests the 'possibility of a more optimistic view of interprofessionality even though harmonious relationships may be only patchy and partial' (p.15; cf. Manthorpe and Iliffe 2002).

This argument seems hard to sustain in the face of Hudson's own evidence, however. His case studies found multiple *intra*-professional as well as inter-professional difficulties. While the received Huntingdon-inspired wisdom may be over-simplistic, it is hard to argue that such conflicts are likely to cancel each other out in some form of creative tension; indeed, they could surely make matters yet worse. Hudson's appeal to 'move on from an unduly pessimistic view' seems to be based on assertions, rather than evidence. These include the view that 'inter-professionalism is a good thing'; that the 'policy climate' is supportive (conflating the intentions of the policy elite with actual performance); and 'academic reasons'. The latter are a growing mutual awareness of the advantages of cross-professional alliances and the fact that shared experiences through team-working can countervail uni-professional hierarchical assumptions, acquired during the process of professionalisation.

Whatever the view on professional collaboration, there is little up-to-date evidence on the evolution of culture more generally. Glendinning's early findings suggest some signs of productive reform, but these must be set against wider constraints and pressures: the implicit message is that overall, the culture of these organisations is still biased by professional and other influences. Moreover, no study has yet reported evidence on the impact on users or traced trends in relation to other stakeholders. One might question whether accounting for these other actors might generate a rosier picture of change.

Only one systematic academic study is currently available on culture as an ingredient across a local system, that is covering service professionals, other workers and employees as well as users. Conducted by Peck and colleagues, it addresses the experiences of those involved in delivering integrated mental health services in Somerset, under the auspices of a Joint Commissioning Board, between 1999 and 2001. The Somerset Health and Social Care Trust, which became the employer of all mental health workers in the county including previous SSD employees, has been a politically and symbolically important case, with the arrangements lauded as a 'beacon' in the NHS Plan (Department of Health 2000).

Given the paucity of other systematic evidence, it is worth noting the findings of this study, together with the authors' interpretation of their results, in some detail.[9] The headline findings have been reported as major failures and disappointments (Peck *et al* 2002). These include dwindling levels of overall satisfaction on most measures amongst a group of 96 users tracked over the period (although 'self-esteem' bucked this trend)

---

[9] Peck has also linked their findings on the 'underperformance' of merger to empirical and theoretical themes evident in the literature on private sector merger, which other health and social care researchers have chosen to ignore (Field and Peck 2003). Unfortunately, this paper does not really discuss the key issue of the appropriateness of applying private sector models and assumptions to the public services, and also does not refer to the academic literature on mergers in the third sector, which might be more relevant; see Cornforth (2002).

and decreases in job satisfaction, role clarity and morale among staff, linked to rising workload and bureaucracy, between 1999 and 2000, although a 'levelling off' between 2000 and 2001. While the governing board had become an 'important symbol' for fostering commitment and brought theoretical transparency, the research team concluded that much of the important decision making was, in practice, displaced by horse trading behind closed doors. They write that 'by the end of the evaluation period, we remained unsure whether the combined trust had delivered anything which could not have been delivered without the transfer of social care staff to the new employer' (2002a, p.27; see also Peck *et al* 2002b for a more detailed discussion of conclusions relating to the Board's functioning).

Perhaps even more important than their empirical findings is these authors' development of a more sophisticated understanding of the cultural processes entailed when efforts are made to integrate an organisation across the social and health care divide. 'Cultural' explanations were favoured by members, senior managers and other staff as the most appropriate way to explain their experiences of change, while users appeared indifferent to or unaware of these issues (Peck *et al* 2001, p.320).[10] But Peck *et al* (2001, 2002) propose an understanding which refers to more than professional groups defending the barricades to protect well defined status, identity, and autonomy. Rather, their meaning of culture also refers to the reflexive process including organisational affiliations and personal attachments, which also requires cultivation for institutional life to function. This is argued to be a process involving 'sites of struggle' (2001, p.323). These include traditional loyalties and interests, but also less visible and fluid attachments; confusion and opacity are seen to be as much a feature of institutional life as *a priori* efforts to foster individual, professional and organisational self-interest.

On this account, the cultural process in Somerset could be approached in terms of three functions:

- Culture as a tool of integration, the normative glue holding together diverse actors. The aspiration towards a 'shared culture' could be seen in these terms, but there was great variation in the actual meanings attached to this, as well as in views on appropriate strategies for achieving it.

- Culture as a tool for understanding and working with difference, the view that overall culture is less significant than the complex interaction between multiple sub-

---

[10] Unawareness or indifference on the part of users does not mean these aspects are not significant in terms of the quality of care they receive. The quality of user-worker interactions is itself a critical ingredient in care as a 'personal' or 'relational' process (Gui 2000; Kendall *et al* 2004). The cultural experiences of both professionals and other carers profoundly affect their morale and hence motivation, and so influence their capacities to interact productively with users, even if this is unobservable and not understood by the latter.

cultures, such as professional affiliations (p.324). Joint professional working was seen to be essentially multi-disciplinary, not inter-disciplinary 'at least in the short term', which could accentuate difference (p.325).

- Culture as a tool of individuals, stressing that 'culture is an enactment neither [solely] of management manipulation nor of professional subculture, but rather the ebb and flow of individual relationships' (p.324). This is the most significant new dimension introduced by this approach, and helps us see more clearly why culture cannot be reduced to the product of professional and organisational components, but also reflects the 'chemistry' of imperfectly informed personal interactions.

There are some difficulties with this research. The evidence relates to only one client group in one locale. If the intention is to analyse *culture* – whose generation and reproduction is inherently a long term process – the timeframe of the research was far too short. Nevertheless, the research does little to dispel the mood of scepticism, and sometimes pessimism, which characterises research accounts on this issue. While this may in part reflect the theoretical frameworks drawn on by the author, which understands cultural evolution as a process of 'struggle' thereby downplaying more consensual patterns, it should be taken seriously. The qualitative findings not only reflect the actual world views of those involved, which in turn must shape their motivation and behaviour, but also are consistent with the researchers' quantitative survey findings.

Social care related 'partnership' as a political process

All systems need a certain degree of stability and order to function effectively. Yet these seem to be conspicuous by their absence at the interface between social and health care. Hudson writes that the politics of care trusts have been characterised by 'confusion' and the appearance of oscillation (undated paper, p.1). This description could also be applied to the development of 'partnership' services in social care related policy more generally.

This confusion might be ascribed partly to the lack of research evidence or clear argument in this area. Evidence-based policy requires a combination of decisive conceptual argument, unambiguous empirical findings and convincing presentation, whereas research seems to lack these attributes (see section 3.3), and often seems to be characterised by a succession of confused and sometimes even contradictory messages. In particular, little consensus has been reached on key issues, such as how to match particular institutional structures, positions on the spectrum from voluntaristic to command driven policy styles, and types of partnership to particular categories of need, forms of care, or client group attributes. The 'oscillation' described could be seen as the inevitable result of attempts to respond to such evidence. Alternatively, it might be argued that decisions are more commonly made on political – rather than technical – grounds, and that the views of policy-makers are established well in advance of receiving research-based briefings from experts.

Yet whatever the difficulties of 'internal' learning from research, the literature draws attention to a variety of ways in which the evolution of these services has also been constrained by its broader 'external' policy and political environment. We explore below the most important of these influences and how they intrude into, and interact with, these services.

Politically motivated public expenditure constraint

In an influential paper, Glennerster and Lewis (1996) suggest that the 'strong normative core' of public expenditure constraint has heavily limited the possibilities for service development in community care (see also Glennerster 2003 chapter 5). While there has been a new political willingness to commit additional resources to services at the health and social care interface in recent years, as well as to social care more generally, new funding streams have built on a long historical legacy of under-investment (see Bornat *et al* 1997; Means and Smith 1998; Bernard and Phillips 1998; Hudson 2000). Although services at the boundary of health and housing can benefit from the buoyancy of their budgets to offset social care budgetary austerity (Kendall 2003 chapters 7 and 8), most

writers emphasise long term neglect, and a concomitant lack of public financial underpinnings.

Public fiscal constraint is shared with other Western countries, and is linked to the prominence of voluntary sector activity. The combination of a historically prominent voluntary sector and relatively low levels of public resource commitment compared to other mainstream activity (such as social security, health care and education budgets) traditionally reflects such factors as a lack of political incentive to invest for electoral or human capital accumulation purposes; the political weakness of the relevant professions and quasi-professional bodies; and comparatively low capital intensity, so that relatively low barriers to market entry are in place, and it is relatively easy for small operators to provide services compared to other public services (see Kendall *et al* 2004 for more details).

The more recent generosity of research funding in this domain may reflect a reconfiguration of some of these factors. These include the rise of user and social movements (collective action geared towards changing public and societal understandings of users' needs, rights, and situations), greater awareness of the economic value of lifelong learning, and, in the case of older people, recognition of the increasing significance of the grey vote. Moreover, to the extent that health professionals have increasingly developed a stronger stake in this field (cf. section 3.4), we would expect knock-on effects in terms of public investment. There are, however, no data to demonstrate such patterns, because this would require time trends evidence on changes in public expenditure at the interface of social care with other services, in comparison to education and health.

The central-local dimension

A history of relatively low resource commitment to social care, compared to other public service fields, is shared with other countries, as is a tendency for government to have more than one tier. Although few countries are as centralised as the UK or involve national government so prominently in the regulation and the allocation of resources, most do involve some form of engagement of national or federal bodies as well as sub-national authorities (Anheier 2000).

Yet one feature which sets Britain apart has been the troubled and often destructive relationship *within* the State - between local and central government (Carter and John 1992). The re-allocation of responsibility for purchasing care to local authorities as a key part of the implementation of the 1990 NHS and Community Care Act (Wistow *et al* 1996) went against the dominant trend of that era: the tendency of central government to use its unique prerogatives to redistribute power to itself and away from local government (Marquand 2004). This apparent political decentralisation was

accompanied by strong central steering, however, and more recently central government has further extended its command and control capabilities in many respects.

A number of problems can be seen to have arisen at local level. Despite rhetoric to the contrary, traditionally low levels of trust between the policy tiers seem not to have been repaired in recent years. Uncertainties and confusion associated with the (potential) shift towards care trusts has done much to inflame and even further undermine this fragile balancing act. Social services departments in general, and the Association of the Directors of Social Service (ADSS) in particular, have proved relatively powerless as this erratic process of proposing, modifying, and retracting possible reforms has unfolded, and many local actors have become increasingly demoralised and demotivated (Hudson, undated).

User-professional relations

A key argument in official accounts is that, guided by central audit and inspection processes, users have been 'empowered' through the expansion of choice, the rolling out of care management principles, and the fostering of supply side diversity. Has power really been transferred from professionals to users? Subsequent sections consider the evidence relating to particular client groups, including links to individual outcomes and measures of well being. Some analysts have also sought to understand empowerment as a wider political concern, addressing the extent to which changes in the political structure have favoured or undermined users' capacities to express themselves as citizens, in addition to their role as consumers.

A useful account of users' situation in relation to empowerment is provided by Barnes and Walker (1996; see also the more recent corpus of work by Barnes, as well as Rummery and Glendinning 2000). They suggest that reform has been 'more radical' here than in any other western European country (p.376). Harris (1999) offers a stimulating review, setting social care users-as-citizens in a comparative perspective. The political problems of defining social care related rights, including a comparison with health and education rights, are reviewed (see also Salter, 199X). While some problems are general,[11] others are specific to the context of social work, including not only a relative lack of resources, but also implications arising from social work's exceptionally high level of intrusiveness into the private domain. This is argued to create a sense of 'second class citizenship' amongst the people who have to resort to such support, and to be inherently conflictual because of the myriad ways in which the rights and interests

---

[11] Such as the mediation by political decisions over spending priorities, the lack of user power associated with social vulnerability, and reticence to press claims because of 'lack of compatibility with the prevailing market ideology' (p.926)

of those involved (users and carers) tend to conflict. Such interventions can also involve high levels of coercion, sometimes creating dramatic news stories, thus fostering the media's antagonism towards the social work profession. In addition, Harris (1999) points out that this field 'militates against a clear focal point for exercising citizenship, unlike, for example, the relationship between education and the school' (p.927).

The relevance of these factors seems to be enduring, but the author also points to recent political gains. First, the rhetoric of official accounts, whatever its impact on practice, can be used ('appropriated') to further users' own political agendas. Second, even if 'a substantive right to receive a particular form and amount of state social work in the light of uncertainty over resources' is 'unlikely' (p.930), the growth in *procedural* rights has been important. Civil rights to a hearing, explanations of decisions in terms of equality and consistency, and provision for complaints and appeals, are all real and significant. Third, to the extent that social care professionals are increasingly encouraged to learn substantively from users, the latter could be said to have made a political impact (although limited time and bureaucratic pressures constrain the 'space' for such learning processes).

Inter-professional power: vertical redistribution

Within the context of difficult central-local relations affecting the smooth operation of partnerships in social care, at least one reform seems at first sight to have rendered the process of policy implementation less problematic: Guidance on meeting continuing health care needs in the community, issued in 1995. It made explicit what were previously implicit or tacit priorities, so that outright neglect is no longer politically feasible (Lewis 1995). There are, however, different ways of being explicit. Senior local decision makers, concerned to avoid responsibility for implementation, have developed local policies which accord with these Guidelines, but which are often vague and unclear, leaving the 'devils in the detail' to front line staff. The problems, in short, are not solved, but displaced. This can be seen as an example of Weiss (1975)'s recognition of the political function of ambivalence.

Inter-professional power: horizontal patterning

The trends in professional influence and interaction seem in many ways to be reproducing deeper power relationships. These are neither straightforward nor unidirectional. There is a paradox here: the trend towards greater health care influence, with its apparently negative implications for social care professionals, has also brought advantages in terms of resource acquisition. As the absolute level of resources at the interface has grown, there may have been an increase in the resources committed to social care oriented priorities, even if these have not grown proportionately. Thus, while

GPs and consultants may have increasingly set the agenda and taken greater control of overall strategic funding decisions under joint governance and working arrangements, social workers and similar professionals have also benefited as the overall size of the pie has grown.

Nor is it a case of simply mixed gains and losses for social care professionals, and outright wins for the medical profession. Although writers have stressed the many ways in which the latter have successfully resisted pressures to limit their autonomy, there can be little doubt that they can no longer ignore the perspectives of other actors, and must now account for their decision making to an unprecedented degree. Strategies devised to discharge these responsibilities tokenistically, or even to avoid them through implementation failures (discussed by Hiscock and Pearson 1999), may become increasingly difficult to pursue, particularly if some of the efforts to develop integrated information systems can be made to deliver.

Methods for audit and control

Some of the system dysfunctions reviewed above involve a significant political dimension. For example, many voluntary organisations, while welcoming recent levels of financial commitment and the broad thrust of new regulatory regimes, have expressed concern about the potentially stultifying effects of 'surveillance' on their capacity to innovate; some argue that this undermines other 'functions' too (Kendall 2003 chapter 8). Indeed, some commentators have argued that the thrust of recent reforms of the social care system has made 'surveillance' a more general problem (Hudson 2000). Prior to 2004 and the introduction of the Commission for Social Care Inspection, the increasingly centralised auditing system had at its apex the Social Services Inspectorate and the Audit Commission, whose analyses and arguments are therefore of great import. These institutions are political in the sense that they wield considerable 'soft' power. Arguing from very different theoretical starting points in community development and social accounting, Taylor (2003) and Power (1997) have pointed to the political dimension of such auditing institutions, and raised very general concerns about the adequacy of the mechanisms holding such bodies to account.

Overall comments: the balance between political processes, epistemic learning and professional culture as a driver of social care 'partnership' developments

The institutions now replaced by the Commission for Social Care Inspection commanded enormous respect amongst many in the field during the period covered by this review. It is important to underline here the extent to which their analyses have been widely welcomed as forthright, practical and useful. However, the Audit Commission/SSI's swan song *Old Virtues, New Virtues* report, one of the few official documents to provide an overview of system-wide developments over a reasonably long period of time, was unduly optimistic, even on its own terms and on its own evidence. Its account of mainstream social care seems to over-generalise and simplify inappropriately. For example, its tendency to treat in-house provision as intrinsically bad, and externally commissioned services as intrinsically superior, is not well grounded in theory or practice. The evidence suggests that there are defensible reasons for a significant local public ownership role. Another example is the argument that 'consistency assured by performance management' should trump 'individual professional duty' (*op cit*, p. 4). In fact, there is no evidence that loyalties to traditional professional values are everywhere dysfunctional, any more than inter-professional working is a panacea in all circumstances. Indeed, such values can be an important motivator for caring, readily co-existing with other professional values as well as with attention to management and economic priorities (Kendall 2000). In addition, what is viewed as 'inconsistency' in care, when viewed through a performance management lens, can be defended under certain conditions. Systems for performance management themselves have limitations and cannot capture all the nuances of needs-related circumstances encountered by caring professionals in their work.

Second, the report underplays, and even ignores, key aspects of 'partnership' in and around social care which must be accounted for if a full understanding of service developments is to be achieved. By choosing to focus primarily on mainstream social care services, the report puts to one side concerns relating to the deeply problematic boundaries between social care and other public services: precisely the conflicts, difficulties and dilemmas that we have surveyed in sections 3.3 to 3.5. Considering social care related partnerships as a process to generate and capitalise on learning does involve some scope for optimism. There have been significant efforts in recent years to widen learning opportunities and lock them in to social care related partnerships. There is also ample evidence that stakeholders are keen to take advantage of such possibilities, and that some of the traditional gloom about social workers' principled resistance to certain forms of evidence-drawing has been misplaced.

Why be sanguine, then? This is in part because implementing learning opportunities has often proved very difficult. Short-term and sometimes unpredictable pressures

generated by the wider policy environment and political backdrop have tended to undermine the stability that need for the system to function effectively. Indeed, it is precisely when one considers the cultural and political context that a more unambiguously negative picture emerges. The sceptical tone that characterises most research may be too hasty because of the lack of long term, systematic evaluation: the jury is still out. But if we consider how political dynamics have shaped the development of social care in recent years, it is much more difficult to avoid an essentially negative assessment. The combination of low public resource commitments, and dysfunctions flowing from central-local government tensions, can be seen as root macro-political causes here. It is possible to be more upbeat about some aspects of users' political positioning, as Harris's thought provoking review (1999) has shown, but this needs to be set against wider political difficulties that continue to bedevil this service area. The continued trumping of social care aspirations, favoured by social care professionals and voluntary organisations, by acute health priorities is one problem; another is the concentration of power in an increasingly centralised apparatus of audit and regulation. These issues and concerns need to be set against the positive picture painted in *Old Virtues, New Virtues* if a mature and sensible debate in touch with the realities of social care is to evolve.

Figure 3.1: Social care supply in context