

REPORT

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Developing social care: the current position



Chapter 9: Reflections

The Personal Social Services Research Unit (PSSRU) at the London School of Economics was commissioned by SCIE to undertake a literature survey on 'Service development trends and gaps'. In this final chapter we offer three sets of reflections from our work.

We start with reflections on social care changes since the late 1980s, particularly as they relate to the resources of social care, the services they make possible, the achievements of those services in terms of outcomes and cost-effectiveness, and the extent to which service users have been offered greater choice. It is unusual to have the task or opportunity to look in some depth at evidence from research, audit, inspection and performance assessment *across* the various social care user groups. Here we will not attempt any in-depth comparisons, but we hope our observations may be helpful.

We will then consider managerial capacity in social care. Our discussion will look at – in the words of the commissioning brief from SCIE – the evidence from inspection and other reports 'about trends in the management capacities and capabilities of social services departments'. We must emphasise that we have not conducted primary research on managerial capacity as part of this project: our comments here are derivative.

Finally, having been exposed to more than a thousand documents – and having fully read the vast majority of them – we cannot resist offering some reflections on the quality and nature of the evidence we encountered. We shall largely avoid the temptation to get involved in epistemological debate about what constitutes good or relevant social care evidence. But some conclusions leap so far out of the thousands of pages that we feel obliged to comment. In some fields evidence was plentiful and solid; elsewhere it was often extremely disappointing.

9.1 Reflections on social care changes

Between 1996 and 2003 all but two local authorities in England received a joint review from the SSI and Audit Commission, each being 'assessed from the perspective of how well it was serving its community and its prospects for improvement' (SSI and Audit Commission 2004). We have already drawn on this final Joint Reviews report (as we shall hereafter refer to it) in some of the earlier chapters, just as we have found it useful to have the final round of SSI summary inspection reports for each of the main service user groups.

The Joint Reviews report suggested that: 'Since 1996, services have changed in five main directions:

- Shifting from institutional forms of care to a wider range of community-based provision.
- From administering care to supporting independence.
- Towards a greater diversity of service providers.
- Towards a more organised approach to matching needs and priorities to services.
- Towards better co-ordination across Health, Education and Housing' (SSI and Audit Commission 2004 p.17).

This list provides a good starting point for our reflections on social care changes, but we would add other dimensions, for example relating to funding and human resources, and also broaden the discussion, for example of independence and need to include the higher profile aim of social inclusion. We need to cast the evidence net back over a longer period, to the late 1980s. We will not attempt to discuss any of these themes or trends in detail.

From institutional to community care

Since the late 1980s the balance of care for each of the five main service user groups distinguished in this report has shifted very significantly away from institutional forms of care and towards community-based arrangements. Despite an ageing population, the number of older people accommodated in long-stay hospital settings is smaller today than it was in 1990 and recent years have seen a noticeable shift away from residential and nursing homes in favour of home care provision. The long-term commitment to close the old psychiatric hospitals was given renewed emphasis and the number of working-age people with mental health problems in in-patient beds fell considerably. In the learning disability field, almost all of the old mental handicap hospitals have now closed and attention has turned more recently to the development of smaller, more individualised and independent 'dispersed housing' options. For looked after children the continued trend has been to consider finding a foster placement no matter how challenging a child's needs. And for people with physical disabilities the dominant aim is now of course to achieve truly independent living, an aim that is changing the balance of care.

These are all major achievements, although not always widely appreciated:

The social care field is almost wilfully bad at celebrating its achievements.
The policy of care in the community, a project on the stocks for thirty-odd

years, was put in place – admittedly not without pain both to service users, carers and to staff, but nevertheless implemented in three to four years – is an amazing achievement. Frail, elderly people with life left to live no longer die in institutions but are now supported at home; the mentally ill no longer live out most of their lives in miserable institutions. Learning disabled youngsters now attend college. We know well the remaining problems, but the empirical research suggests that if political nerve is kept, then this approach is capable of working. The real problem is that the policy acquired a political virus during its long period of gestation; in other words, the commercialisation and privatisation of services went hand in hand with it (Sheldon and Macdonald 1999 p.16).

Shifting the balance of care has not been without difficulties. Among the challenges that have had to be faced by the social care sector – and generally these challenges are still there – are the following:

- overcoming perverse financial incentives, especially difficulties in transferring resources across agencies or budgetary boundaries;
- making the political commitment to higher costs in the short run ('hump' costs) arising from the need to invest in new community services and systems;
- developing models of care for people with high support (high cost) needs that do not involve out-of-area placements in semi-institutional settings (Examples would be placements for some people with physical disabilities, children with challenging behaviour, people with mental health problems who might otherwise be accommodated in low secure settings);
- minimising the risks of adverse events while maximising the opportunities for independence;
- training the workforce needed to support people in more independent settings;
- offering flexibility in community services to widen the choice range for individuals who need support.

Greater diversity of provision

The Joint Reviews report rightly emphasises the growing number and increasing variety of providers, but could equally have pointed to the growing diversity of services per se. Thus alongside the (often rapidly) increasing market shares of the private and voluntary sectors there has been the introduction and development of new service types and

processes. A non-exhaustive list of examples would include: intermediate care, supported employment schemes, person-centred planning, intensive care management, crisis teams, early intervention services, new forms of day activity settings, and housing with care.

The changing sectoral balance of provision came through clearly in our description of trends in many services. We will not repeat the details here or the underlying forces that brought about these changes, save to register that there were clearly many common elements working across service user groups. It would be interesting to speculate on the reasons for the *differences* – often very marked indeed – between user groups and services in the rate of change in market share, the degree of retention of in-house services, the balance between private and voluntary sector provision, the rate of concentration of provision in larger corporate bodies, the relative costs of in-house and independent sector services, and the extent and influence of privately purchased care. Why is it, to take one example, that private and voluntary sector providers tend to dominate the specialist end of the market for child care services whereas they are relatively much more concentrated at the ‘generic’ end of markets for older people’s services? Such discussions must wait for another day.

An emerging problem – or perhaps it is a long-standing problem which now has wider recognition – is the financial fragility of many small providers. A great deal of attention is currently being paid to closures (and also changes of ownership) of care homes for older people. In some localities the rate of closure is not proving to be a problem because more intensive community-based services have reduced the demand for care home places, but the pattern of closures has not been planned or controlled in any strategic sense. While central and local government have been endeavouring to ‘manage down’ care home provision since the early 1990s, many (perhaps most) of the closures of recent years have been influenced more by the impending introduction of new quality standards and the booming of the property market than by the downward pressure on prices applied by many local authority commissioners (at least until recently). It would be wrong to make too great a distinction between these various influences, because were it not for the downward pressure on prices many care home owners would not have felt the need to leave the market. Nevertheless, recent experiences emphasise the vulnerability of social care markets to the various influences of external forces. Most attention in the media and in policy discussions has rightly focused on care homes for older people, but there would appear to be lessons for other services and user groups. Market conditions (and market management skills) are admittedly very different, but financial fragility and supply vulnerability are surely just as possible. Potentially, they could even be more damaging.

Attending to human resource issues

Recruitment and retention of social care staff have long been challenges for the public and other sectors, and across each of the service user groups and most of the services covered by our review. Whether the challenges have grown over time is not clear, but certainly the attention paid to them today would appear to be greater. On the positive side, the Joint Reviews report concluded that local authorities' responses to these challenges were getting better:

Systems for communicating with staff have improved over recent years. Councils have made efforts to recruit staff that better reflect the diversity of their communities, with noticeable impact in some places. The management and development of staff presents a more improving picture. More structured supervision, performance appraisal and tailor-made training and development arrangements are in place than was the case in 1996 (SSI and Audit Commission 2004 p.44).

Nevertheless, unmet training needs would appear to be prevalent in areas such as: communication with people with learning disabilities, managing challenging behaviour without recourse to sedating medication (for all service user groups), supporting people to take up direct payments, and analysing assessment data and translating it into needs-responsive (outcome-generating) care packages.

A basic, pervasive and persistent recruitment problem is the level of pay relative to responsibility. Looking at home care workers, for instance, is it surprising that not many people want to work unsocial hours in a low status job for very low pay? But there are also vacancies in what might be seen as higher status, certainly higher paid posts such as the variety of keyworker positions now being introduced more widely across the service user groups.

Over the period since the late 1980s, increasing attention has been paid to the needs of unpaid carers, and there is now a greater awareness of the impacts of unsupported caring responsibilities. But research on those needs and evaluations of services to meet them appears uneven: for example, there has been rather more work on carers of older people than on carers of people with mental health problems. Young carers are still not getting much attention. Reliance on informal care is going to grow over coming years. Information on volunteer workers is scarce.

Matching needs and priorities to services

A central concern of the 1990 Act was to improve the assessment of, and service responses to individual needs. The Joint Reviews report noted that services are now 'more focused on priority needs' (p.3). Improvements can be seen across the service user groups, although as ever the reality on the ground does not always match the intentions of the policy architects. For instance, person-centred planning was a central plank of the 2001 learning disabilities White Paper, but its development has been quite slow and a number of informed concerns have been expressed as to whether it is affordable or indeed desirable. To take another example, the models of care management for older people that were found in research studies to generate good user outcomes at an affordable cost have only occasionally been found in everyday practice in the years since they were first advocated. A large proportion of assessments are not completed on time, and there were delays in some localities in introducing the Single Assessment Process. Case management and care programming arrangements introduced into mental health care systems demonstrated clearly that two good ideas are not necessarily better than (or even sometimes as good as) one.

There has been an explicit and indeed successful policy in relation to older people of targeting services on users with the greatest needs. Targeting for other service user groups appears to have been either not as explicit, or not as successful in its implementation. Of course, the term 'success' must be interpreted carefully, because there is relatively little evidence on the wider consequences of such intensive targeting of older people's services. In particular, we do not know what the implications have been for people who are now no longer able to access state-funded services. The introduction of 'functionally differentiated' community teams in the mental health field (the new assertive outreach, crisis resolution and early intervention teams) might represent an equivalent aim of focusing skilled professional resources on small groups of people with particular or 'priority' needs. It is not clear what this might imply for those people who, as a result, receive poorer access to services (if indeed that happens).

It might be argued, therefore, that the targeting of services on people with the greatest needs is undermining the preventive function of, for example, low-level or less intensive home care. On the whole, and trying to generalise from pretty limited information, over time there appears to have been more attention paid to preventive services, although it is not clear how far resources have actually followed intentions. Nor is it clear whether the action that *has* been taken has been proactive or reactive. There has certainly been a push to mobilise and support informal care, but is this a reaction to crisis in the form of excess demand and escalating costs, rather than a commitment to put in services earlier to promote carer well being, or does it not make sense to separate the two? The funding challenge is obvious: there needs to be some initial investment and a period of 'double running costs' while new preventive services are building up but not yet generating much of an impact in terms of reducing the need for high cost services. One

exception to this general description is the heavy investment in a wide range of early years services. These are intended, among other things, to prevent children and families needing to use services in the future and of course to improve quality of life.

People from black and minority ethnic communities are less well served than people from the white majority. This disadvantage has been noted for each of the service user groups, as has the recent commitment to culturally appropriate services. Progress remains slow.

A feature of policy discussion across the service user groups has been some reconceptualisation or reorientation of need. Staff are enjoined to see 'people in the round' and services are encouraged to offer 'whole systems' responses. In policy language, there is greater accentuation of the positives (promoting independence, choice and control) and less of the negatives (overcoming 'problems', compensating for deficits; reducing 'shortfalls'). Emphasising social inclusion is an obvious part of such reorientation. There is still a huge amount to achieve in everyday practice, but there are already some changes on the ground: the emphasis on supported employment rather than sheltered work settings, the broadening of need domains in the LAC and Single Assessment Process frameworks, and of course the strengthening commitment to service user participation and choice.

Supporting independence and promoting choice

A central plank of much public policy today is the promotion of choice. In social care this means promoting service user participation, independence and empowerment, although lack of service diversity (or indeed a basic lack of services) will clearly limit the choices that are actually available. Indeed, for a system to be able to respond to users' choices requires margins of spare capacity and an accompanying willingness on the part of managers and politicians to allow services to operate at less than full capacity. And how many foster care placements *should* one offer to children to give them a choice of where they go? The reality is often the difficulty of finding any placement at all. In the learning disability field there is now a reluctance to set service targets because this would be incompatible with the flexibility intended in person-centred planning. Does choice therefore necessarily come only at higher costs?

Other unanswered questions are whether choice leads to improvements in service quality (through the exercise of consumer pressure, for example) or to improvements in user outcomes. A SCIE Position Paper by Carr (2004) argues that 'service user participation is often driven by process rather than outcomes: organisations want to be doing the right thing, but there is very little evidence that when it comes to putting the views of service users into practice, this actually takes place' (SCIE media release 10 March 2004). Another question concerns the areas over which users will 'be allowed'

choice – what is the boundary between consultation and coercion? This is relevant where the local authority or NHS has statutory powers of protection (of the user and/or society).

The experience that has now accumulated in relation to the needs of people with physical disabilities warrants attention. It is clear that there is still a great distance to travel in the physical disabilities field, and our review has revealed many unmet needs and confirmed the existence of many impediments to service user independence and control. Nevertheless, there have been breakthroughs and therefore potentially generalisable lessons. Among other things, the greater uptake of direct payments for this group than for others, and therefore the greater experience in the day to day operation of direct payments, ought to offer a guide to people working in other areas of social care, and of course an encouragement to other service users. The generally slow rate of take up of direct payments is however an indicator of the progress still to be made. A CSCI report published last month pointed out that although local authorities annually spend £10 billion on social care, only 13000 people have control of the services they use through direct payments.

Better inter-agency working

Partnership may be an over-used term, but there have been important new alliances created across agency boundaries for each of the social care service user groups. Different alliances are obviously needed for different user groups, but common to all is the growing number of allies. Joint planning, commissioning, team working and provision have all become more commonplace, although they do not always deliver improvements. The SSI and Audit Commission reflection is insightful here:

Joint reviews have found that partnerships are more successful where they are seen as a means to an end rather than an end in themselves.

They work best where:

- there is clarity of shared purpose in user outcome terms;
- there is clarity of governance and decision making;
- there are wins for each partner;
- there are efforts to establish a common culture;
- there is explicit agreement about risk and resource sharing;

- attention is given to staff development; and
- there is agreement about the yardsticks for success.

They are less likely to be successful where:

- they are driven purely by national directive;
- they are essentially budget driven; and
- there are major differences of culture and governance (SSI and Audit Commission 2004 p.35-36).

Professional and organisational cultural barriers are still widespread and the new budget flexibility powers are still rarely used, but at least there are some developments. Whether those new partnerships empower social care (as in learning disability) or engulf it (as often seems to be the case in mental health) remains to be seen.

There do still appear to be problems of co-ordination at transition points. These problems can arise at key ages (children moving to adult services; adults becoming 'older people' for the purposes of service delivery), at agency connections (health to social care and delayed discharges), at times of crisis (sectioning and de-sectioning of people with mental health problems), in the spatial domain (tracking when people move areas – there is still something of a postcode lottery in service provision), or at service change points (care home closure, unplanned placement changes).

Developments in funding and expenditure flows

Expenditure on social care has grown in real terms over the period of this review, although some of the growth came about as a result of the redirection of money previously reaching services through social security channels and some of the growth represents substitution for health service expenditure (such as that formerly spent on inpatient provision for people with learning disabilities and people with mental health problems). However, it is difficult with existing statistical collections to paint a comprehensive picture of funding patterns and trends in what is an increasingly complicated mixed economy of social care, and so also difficult to know the *overall* scale of the funding change.

Whether apparent recent rates of growth will be maintained is debateable. The July 2004 spending review announced that social services expenditure would be expected to rise by less than 3 per cent each year over three years, with most of the growth coming

in 2005/06 and little in the subsequent two years. Local government efficiency savings of 2.5 per cent per year could mean almost no real increase in social care spending.

Overall reflections on service changes

Two quotes from the Joint Reviews report helpfully summarise these recent experiences:

There is evidence of overall steady improvement in social care services over the last seven years. Social services are held in relatively high regard by those who use them. However, there remains too big a gap between the best and worst councils and between what a council aspires to do and the experience of users on the ground. There is now a good understanding of the ingredients of success, but no direct connection between level of spending and successful outcomes for people (SSI and Audit Commission 2004 p.49).

We would have doubts about the accuracy of the final remark in this quote as we have not seen any analyses by the Joint Reviews team (or their parent bodies) that would be robust enough to provide a valid test of the hypothesis that spending and performance are unrelated. We would suggest that this warrants further investigation.

Steady improvements there may have been, but the second quote from the Joint Reviews report contains a warning:

There are no grounds for complacency when:

- user satisfaction levels are not improving;
- outcomes for children looked after still lag markedly behind the rest of the population;
- the numbers of children within the looked after system continue to grow;
- there remain major service gaps and waits in the system, notably for children with disability and mental health needs, older people with a mental health problem, and carers;
- there are great variations in the availability of independent living and rehabilitation opportunities across councils. In many places options have yet to be mainstreamed;
- the number of users able to choose to manage their own care is still lamentably low;

- workforce problems impact adversely on the quality of users' experience; and
- financial crises continue to destabilise councils' social services (SSI and Audit Commission 2004 p.49).

9.2 Reflections on managerial capacity

What can be learned from inspection and other reports about the managerial capacity and capabilities of social services departments? We have already drawn out numerous findings in earlier chapters, and so here we offer only a few summary remarks.

A point to emphasise is that the managerial task is pretty tough.

The shape and nature of social services authorities have shifted markedly between 1996 and 2003. Social care is now the most complex service to manage in local government: the scope of its responsibilities range across all ages, encompassing highly sensitive and sometimes high profile statutory interventions to protect people, as well as arranging a whole menu of services to offer support and rehabilitation. Matching demand and resources has always been a significant issue. In the context of the growing volume of requests for help, the extended range of service options, the integration of resources with others, and the rich tapestry of providers delivering services, the task has become immeasurably more challenging (SSI and Audit Commission 2004 p.32).

There has been change aplenty – social care has been a fast moving field over the past decade and a half – and one dimension to reflect upon, therefore, is the management of change per se. We can also look at the management of finances, human and other resources in response to need, markets and partnerships.

Managing finances

In the domain of financial management, many improvements can be seen and have been evidenced by audits, inspections and performance reviews. Today there is more long-term planning of budgets, better linking of activity and finance, better understanding of what things cost (particularly in relation to in-house services, but not in relation to care management), better appreciation and realisation of potential efficiency savings by contracting services out to the independent sectors, a more transparently comparative and competitive approach to decision making encouraged by Best Value (although the associated quality management is perhaps poor). Overall, 'better organisation and management has helped to ensure more consistent, equitable, cost-

conscious social services' (SSI and Audit Commission 2004 p.45). However, commentators have also pointed to the 'major challenges' that remain for many authorities, and – according to the Joint Reviews team – overspending of budgets was more common in 2003 than it was in 1996 (80 per cent of those reviewed were overspent in 2002/03). Poor tracking of expenditure and projection of future demands were among the reasons. Among the consequences is the need for short-term expediency, resulting in poorer access for service users, and the distraction of managers from longer-term strategic developments.

While financial management skills have undoubtedly improved, there is still not the confidence or willingness to consider devolving budgetary responsibility down to fieldwork level. Budgets have certainly been devolved farther than they used to be, to cost centres such as services and teams, but not to the 'per person' level. The hesitation about encouraging a greater take-up of direct payments is perhaps also symptomatic of this reluctance.

Managing resources

In her summary of SSI inspections of services for people with physical disabilities, Clark (2003) noted that a lack of management capacity – alongside shortages of skilled staff, financial pressures and the absence of a national policy framework – was likely to threaten the achievement of planning targets in relation to services for disabled people. The summary of inspections of learning disability services drew attention to limitations in the assessment and management of quality and service performance:

Only a minority of councils had what could be called a complete quality management system. However, we found that most councils had some form of performance management. Councils used a range of techniques for gaining input from key stakeholders, including surveys, focus groups, and conferences. Some councils had specialist communication workers to gain feedback from people with complex needs and communication difficulties. Three councils had made great efforts to gain feedback from people from minority ethnic communities. There was much more to be done in councils with small numbers of people from minority ethnic communities (Cope, 2003).

The Joint Reviews team drew attention to problems with the agreement and application of eligibility criteria:

Early Joint Reviews frequently cited evidence of inconsistencies of response to requests for help from councils. Failure to agree, often at a political level who was eligible and not eligible for a service, left the front line applying their own rules. Waits and delays in the system were not quantified and reviewers

relied on contact with users to get a sense of the size of the problem. Case examples of inconsistency littered review reports (SSI and Audit Commission 2004 p.25).

Over time there were improvements. The Joint Reviews report authors suggested that some authorities talked the managerial talk without necessarily putting the new ideas into practice, but elsewhere business planning, performance targets, Best Value reviews and the use of modern technology had led to contributed to service improvements. 'The best results have been found in councils where a modern, business-like approach is underpinned by the values of social care and why it matters to communities' (p.3).

Managing markets

Market management capabilities are questioned by the Joint Reviews team. In many localities the mistrust and misunderstanding of independent sector providers that was so prevalent in the early 1990s appears to persist. Unimaginative, sometimes aggressive commissioning approaches have left independent residential and home care services 'increasingly fragile over the years' (SSI and Audit Commission 2004 p.36). Nevertheless, their over-arching assessment is that there is 'more intelligent commissioning of services' (p.47).

Most attention – both by local authority commissioners and by people commenting on the management function and capability – has been focused on care home and home care markets for older people. The challenges of managing other social care markets are probably also considerable, but somewhat different. Older people's services are high volume and, for the most part, still seen as somewhat generic. For other user groups, market management concerns have perhaps been focused more on specialist services for relatively small groups of service users with particular needs. In some of those markets independent sector providers have often established some degree of market power, whereas in markets for older people's services the power is more likely to reside with commissioners.

It is clear, however, that local authorities' management capacities have grown enormously in scope and quality over the period since 1990. It is sometimes hard to remember how under-developed were the commissioning skills of authorities in the early years of implementation of the 1990 Act. There are still many skills to develop, and many market management challenges to be faced (some of them revealed relatively recently by the rapid closure of care homes in some localities, for example) but change has generally been positive.

Managing partnerships

The Joint Reviews report found that many local authorities had reconfigured their departmental arrangements, integrating children's services with education, or adult services with primary care or housing. There was marked growth in the number of integrated assessment and care planning teams (in the learning disability and mental health fields particularly) and integrated service provision in many areas. Structural change of this kind was not sufficient on its own to bring about improvements: without the development of shared values and a common culture, and the involvement of staff and users, structural change could be an unhelpful distraction. Not surprisingly, as we noted earlier, the Joint Reviews team urged health and social care agencies (and other bodies) to see any new partnership as a means to an end rather than an end in itself. Similar advice came from some of the summary SSI reports:

Organisational change is a necessary part of the reform of mental health services. But it can easily dominate activity and dilute good services. It requires clear focus and leadership, and attention to human resources, from a management capacity to the caseloads of individual team members (Robbins 2004 p.2).

Robbins details the partnership working and the progress being made in the mental health field. She argues that 'better performance and prospects for improvement' (pp.21-24) are associated with a number of organisational and managerial arrangements, including effective joint management and corporate governance, unified management of multi-disciplinary teams, senior managers being committed to the service development agenda, focus planning and implementation structures, active engagement with users and carers, continuing commitment to a holistic approach to mental health, engagement with non-stigmatising providers of mainstream services, and good quality information.

Managing change

A lot of attention is focused today on change management, and we have been able to reflect on how inspections and audits have viewed the capacities of local authorities. What is not always appreciated is the enormity and rapidity of change. Some targets and timescales have simply been impossible for authorities or services to meet. A good current example would be the short timescale set for getting crisis resolution teams in place for people with mental health problems. Although there has been a great deal of progress, the target of 330 teams by 2004 is going to be missed by some wide margin. This is probably not a failure of management but the setting of an unrealistic timetable. Moreover, concerns have been expressed that the need for such rapid change in setting

up the new functionally differentiated mental health teams might result in the (unwanted) diversion of resources away from established generic services.

In identifying 'some immediate priorities for local managers and practitioners', Robbins highlights the challenge of managing so many changes in the mental health social care system in quite short spaces of time:

anti-racist and culturally-appropriate services which serve all people well; genuinely joined-up work to tackle the complex problems of people with dual diagnosis; real jobs and really flexible housing options for people recovering from mental health problems; effective marketing to boost take-up of direct payments, and training for staff; and HR management which supports, develops, and retains valuable human resources. Implementation of this agenda will involve major challenges for management, if service quality is to grow at the same pace as service innovation (2003 pp.33-34)

In relation to services for older people, local authorities had not always risen to the challenge:

Inspections showed that social services' ability to manage change effectively was variable and sometimes poor. Leadership in transforming strategic direction to achievable plans and good outcomes was clearly a key issue. Where change programmes were ineffective, the cost to councils and their partnerships in terms of poor outcomes for older people was significant. Senior management teams should identify the skills they needed and ensure that either they had those skills within their team or could access them in other ways (SSI 2003 pp.7-8).

Overview of management capacity

What are the overall assessments of managerial capacity and achievement? Certainly all of the audit and inspection summary reports that we have looked at pointed to the many management challenges that have to be faced: a fast moving field, a whole raft of new responsibilities, growing expectations about quality and effectiveness, the demands of new skills acquisition, the intense and growing public scrutiny of the personal social services, the large and growing 'external' market, the need to work within sometimes uncertain local political contexts, perennially low investment in management information systems, pressures to work in a host of new partnerships with agencies that are themselves undergoing often very rapid or profound changes, the desire to involve service user and carers in decision making, the requirement to ensure service flexibility in response to changing patterns of need and preference, and of course increasing amounts scrutiny from auditors and inspectors.

The overall response is rated as quite encouraging (SSI and Audit Commission 2004). There is more strategic management, a clearer sense of direction, better translation of intentions into commissioned services, more partnership working, wider use and wider ownership of performance appraisal systems 'to regulate and assure', an improved focus on users and carers, and greater cost consciousness. Poorly performing authorities have insufficiently robust systems for planning and commissioning, overspent budgets, difficulties with workforce recruitment and retention, and generally the distractions of crisis management (p.45). But overall:

This overview acknowledges that overall social services are better organised and managed than they were in 1996 and cites the quality of leadership and management as the key factors driving improvement. It concludes that the best results have been found in councils where a modern, business-like approach is underpinned by the values of social care and why it matters to communities (SSI and Audit Commission 2004 p.3).

9.3 Reflections on the quality of the evidence

The personal social services are large-scale experiments in helping those in need. It is both wasteful and irresponsible to set experiments in motion and to omit to record and analyse what happens. It makes no sense in terms of administrative efficiency, and however little intended, indicates a careless attitude towards human welfare (Seebohm Report 1968 p.142).

Evidence is certainly being gathered but its quality is sometimes rather poor. In discussing the evidence it is helpful to distinguish four main sources. Each is intended to be publicly accessible, an accurate reflection of reality and hopefully generalisable. These sources are:

- the collections of activity, resource and experiential data by local authorities (as commissioners or providers) and by other agencies delivering services;
- the inspections and audits usually carried out by central government or agencies appointed by it;
- the assessments of aggregate performance using statistical indicators routinely collected (usually) by central government; and
- the research conducted by university-based and other individuals or teams.

In reflecting on these sources, we need to be aware that each is carried out for a slightly different purpose. Moreover, there is a wealth of other information on which social care

policy and practice should and does build. This includes the professional expertise and preferences of the staff who manage, purchase and deliver services, the judgements of those people elected to take strategic decisions, and – most importantly – the experiences of the people who use social care services and their families. Here we are concerned with those experiences and judgements of staff, politicians, service users, families and carers only in so far as they are captured by one of the four sources of publicly available evidence distinguished above (such as through local surveys of users or interviews conducted by inspectors).

Local evidence

We have not been able to look at very much locally generated evidence – from service providers or commissioners – except where it has been disseminated in publicly accessible form. Most locally generated evidence remains in-house. It has bounded generalisability. The Joint Reviews team observed some improvement over time in the local use of structured data. Performance management was seen to have moved from being disorganised and sporadic in the mid 1990s to being ‘firmly established’ by 2003. National indicators were now being more widely used to assess progress in meeting local priorities. Lessons were being drawn about how best to use information:

Having the information and using it to support action are by no means the same thing. Joint Reviews have found good management information is used to best effect where councils:

- are information conscious and evidence driven;
- involve the front line to construct indicators and reporting systems;
- take a wider view in analysing and interpreting data;
- use activity, cost and quality measures side by side;
- share information to give feedback to staff and partners;
- put information in the public domain; and
- strive to constantly improve the quality, relevance and accuracy of information (SSI and Audit Commission 2004 p.39).

But questions have been asked about the quality of some of the information that is locally generated and employed.

Social services departments undertake a great deal of 'in house' research, including outcome or effectiveness research. Most such research is at the weaker end of what would be seen as a hierarchy of research methods in health [Macdonald's benchmark in this paper], i.e. non-experimental methods and surveys of users' views, though of its kind it is often of good quality... Such methods fit most easily with the working realities of many departments and have an important part to play in routine monitoring and evaluation (Macdonald 1999 p.26).

Problems obviously arise when decisions are taken on the strength of inadequate evidence, and unfavourable contrasts might be made between the local 'research culture' in social care and that now often found in PCTs and NHS Trusts. This is obviously no reflection on the calibre or commitment of staff but on the utterly different cultures of and therefore attitudes to what research means.

Inspections and audits

The evidence coming from inspections and audits appears to have a considerable impact, certainly on local decision makers and probably also at national level. It is of rather mixed quality. Indeed, it is not always clear if the policy and practice recommendations from the Audit Commission and SSI are really evidence-based. One can contrast publications from the Audit Commission and SSI with the NSFs for older people, people with mental health problems and children. The latter have solid, well referenced evidence bases, whereas the Audit Commission and SSI both appear (from their citations and data displays) to draw only on their own local audit and inspection activities and the associated data collations. In contrast, while the evidence generated by academic and other researchers has the potential to be conceptually more robust and to be constructed within exemplary designs, much of it is nothing of the sort, and often such work is also poorly grounded in the everyday realities of social care practice, too narrow in coverage and out of date before it gets published.

Coverage of the evidence from inspection and audit sources is generally good in at least three senses. First, the evidence is drawn usually from a fairly wide sample of localities, although representativeness is not usually discussed (not a problem for a single locality inspection; more problematic when trying to interpret summary reports). Second, evidence is often collected from a number of different people within those localities: from service users, carers, front line staff, middle and senior managers, sometimes also elected and appointed members. Third, the coverage is good in the sense that it usually picks up most of the elements or phases in the organisation and delivery of care, from funding levels, resource inputs, services, individual packages of care and sometimes also service user satisfaction. In all three respects, the coverage of inspections and audits is better than the coverage of the research literature, to which we

turn in a moment. One reason for this is because decision makers need to understand how each of the various parts of the social care system is functioning, and for this they need inspections or audits that span the full set of actions and their consequences (or almost full, as we shall note in a moment) and that can be seen to have national generalisability and relevance. Another reason might be the capriciousness of the research-funding environment. Some commentators also lay some of the blame at the door of the research community (see below).

However, the coverage of this style of evidence-gathering process is inadequate when it comes to the impacts of social care on service users and their families. It is obviously very relevant, and probably very robust, to collect evidence on, for instance, delays that older people face in receiving the equipment for which they have been assessed, or the delays they face in moving out of an acute ward into a more appropriate community setting, or the availability of better day activity facilities. These are all good 'intermediate output' indicators. They show that the work is being done and that services are being delivered to individual clients in a timely or appropriate fashion or setting. But these indicators do not tell us whether the services are addressing the wider set of needs for those individuals. That is, they tell us nothing about the final outcomes.

The paradox is sometimes rather stark, as illustrated by this quote from the SSI report on the summary of inspections of mental health services from a social care perspective.

The government's vision for mental health has become steadily clearer. Mental well being is for everyone, affects everyone. Services are to be developed around people, and will be judged by the outcomes they produce for the people who use them (Robbins 2004 p.3).

It is therefore disappointing that this review does not actually go on to discuss outcomes but remains focused on process and service development (albeit in illuminating ways).

It is not enough to rely on user satisfaction surveys and to suggest that these indicate that all is well (or not) in the social care world. The report on joint reviews by the SSI and Audit Commission (2004) gives a telling illustration of the limitations of satisfaction measures. Two quotes make our point.

The overall views of users and carers have remained relatively static over the life of Joint Reviews. Since 1996, an average of 70 per cent of users and carers have rated the services they receive as excellent or good, a very creditable result (SSI and Audit Commission 2004 p.8).

Some caution is warranted before making an assumption that lack of improvement in user rating reflects a failure on councils' part to improve the

services on offer. The last seven years have seen changes in consumer attitudes to public as well as private sector services. People are less deferential, better informed of their rights and more likely to demand a better service. There are persuasive arguments that expectations are rising in line with the improvements councils put in place. Many councils have made real efforts to involve users and carers and give people a voice in shaping services. Not unreasonably that voice is used to press for further change (SSI and Audit Commission 2004 p.9).

So, on the one hand, the report refers to static levels of user satisfaction, and suggests that this is creditable. On the next page, however, the report notes that satisfaction is context-specific and actually those static views should be interpreted as improvements. If user satisfaction is influenced by the expectations and aspirations of service users, and we would certainly agree that it is, how is it possible to place much reliance on aggregations of satisfaction ratings, or comparisons across time, or comparisons between localities?

A number of other authors have been critical of satisfaction measures, particularly when no theoretical or conceptual justification has been built for them, when data are gathered using ad hoc scales without any known validity or reliability properties, when it is forgotten that many people rate familiar environments more highly than unfamiliar environments regardless of objective quality, when it is also forgotten that long-term satisfaction dispositions are remarkably stable, and certainly when attempts are made to analyse cross-sectional satisfaction data without regard for contextual factors. These major drawbacks are relevant whether one is looking at mental health care (Ruggeri 1994), palliative care (Aspinal *et al* 2003), services for learning disability (Stancliffe *et al* 2004) or services for older people (Foord *et al* 2004).

Another limitation of the evidence produced from inspections and audits is the neglect of local social care system contexts. We can illustrate this point by reference to the SSI and Audit Commission (2004) report although it has wider relevance. The report compares social care expenditure with performance scores to suggest that there is no relationship. The report does not appear to mention that local circumstances, not least local resource market prices and local needs, might have some influence on either the performance indicator or the cost measure. We would have expected adjustments to be made for the characteristics of authorities or localities which are beyond the immediate influence of local authorities or social care systems, such as levels of deprivation, population movements, demography and levels of need.

Performance assessments

We welcome the considerable developments in routine information collection in the social care field. More and better measures are being employed. But, as we noted in earlier chapters, and as is clear from what we have just written, the indicators within the Department of Health's performance assessment framework measure input, process and service volume, but do not measure the impacts of services on service users or carers. Performance indicators are therefore 'outcome-light'. Outcome measurement requires assessment of change over time, comparing one service situation with another. By definition, therefore, cross-sectional surveys cannot generate outcome evidence. This obviously represents a pretty fundamental challenge for any annual performance assessment system. The key question remains largely unanswered: what is the (evidence-based) association between the activities measured by performance indicators and effectiveness in terms of improvements in the quality of life of service users? Some of the literature examined in chapter 4 questioned whether existing performance indicators actually relate very well to performance. If we do not know, can we be sure that the set of performance indicators is appropriate?

As we noted in chapter 3, systems for performance management cannot capture the nuances of needs-related circumstances encountered by caring professionals in their day-to-day work. This may be a problem of aggregation and the need for summary measures of progress. But there is also the danger that a performance assessment framework might create perverse incentives that actually undermine care work. For example, Foord *et al* (2004) discuss some of the consequences of introducing what they call a 'culture of performance measurement' for sheltered housing. One positive outcome has been to stimulate providers to examine whether they are meeting the changing needs of tenants, and generally to be more responsive to needs. But Foord and colleagues question whether satisfaction surveys actually help to improve services. They are concerned that providers will be too concerned to 'watch their backs' by meeting the performance standards required of indicators, at the expense of actually getting on with improving services and outcomes for users. Sheldon and Macdonald (1999) raise a similar question:

The social services were once seriously under-managed but, just consider, is there not now an equal danger, as in health and education, that all-pervasive control, target-chasing and inspection has tended to suppress the individual initiative and judgement on which the quality of services ultimately depends? (p.17).

Research

One of the major policy pushes of recent years has been partnership. What, then, is the state of the evidence base? A NIMHE (2003g) booklet on partnership working between health and social care in the mental health field was highly critical of the available evidence. Most of the material found in their review reported the views of policy makers, managers and staff about partnership working, but not the views and experiences of service users and carers. Most of the evidence seemed to be drawn from localities with strong histories of joint working and joint activities, and rarely looked elsewhere. The negative consequences of partnership working were not explored, with attention focused predominantly on positive messages. And much of the literature represented 'essentially journalistic accounts of apparently successful schemes, emphasising the virtues of partnership working without necessarily citing evidence for the claims made' (p.6).

Sadly, an equivalent set of criticisms could be levelled at research on many of the other key themes and trends in social care over the past 15 years. Too much of it is shallow, opinionated, subjective and quite possibly biased. Worse, perhaps, too many studies have been poorly designed, poorly executed and poorly interpreted. 'We suffer in our field from a worryingly high chaff/wheat ratio in the output of research' (Sheldon and Macdonald 1999 p.17).

We found many quantitative studies that had collected data that were not demonstrably valid or reliable, from or about service users who were not demonstrably typical of the wider population, living in localities that may or may not have been representative of the wider picture. The data were often analysed statistically in ways that simply do not stand up to scrutiny. Much of it was descriptive and presumed but not did not test causality. One fundamental problem, perhaps, is that there is widespread 'antipathy towards the deployment of scientific methodology within social care' (Macdonald 1999 p.27). We also found a great many qualitative research studies, a number of which we would interpret to be similarly faulty, focusing on individuals from whom it is unclear whether generalisations can be made, collecting information in ways that were not described in the reports or published papers, and analysing the information in ways that was not obviously reproducible. The interpretations of quite a lot of the quantitative and qualitative evidence that we have looked at often seemed to be somewhat partial, in both senses of the word: neither complete nor disinterested.

Large sums of money are currently invested in evaluations that are technically not capable of providing the answers to questions about 'What works?' ... Despite a series of initiatives intended to promote evidence-based practice, most are fundamentally compromised by the unwillingness of funders, particularly at government level, to address important epistemological issues. Together with a lack of investment in rigorous

primary research this threatens the future of this approach to social care, with the ultimate costs being born by service users and carers, and possibly by professionals who are unable adequately to demonstrate their 'value-added' (Macdonald 1999 pp.30 and 31).

The Commission on the Social Sciences, set up by the Academy of the Learned Societies for the Social Sciences, recently reviewed 'the nature, focus, status, health and contribution to society of the social sciences in Britain'. As Huxley and Evans (2003 p.546) note:

Social care is singled out [by the Commission] as one of the areas which is 'riven with disputes as to what constitutes appropriate evidence, and divisions between qualitative and quantitative paradigms' (p.73). It is time to move on – unless we do, evidence-based (or evidence-influenced) practice and high quality research performance will continue to elude us.

The fundamental problem with all sources of evidence – research, inspection, audit, performance assessment or local intelligence gathering – is similar. It is the challenge of generalisability. Too many research studies carried out by university and other teams fail to design their studies in ways that would ensure or at least ease the task of generalisation from the empirical findings, whether generated using qualitative or quantitative methods. Too many of the evidence assertions coming from inspections, audits and performance reviews are based upon measures which are of generally unknown validity and reliability, are not very thoroughly analysed, and are not interpreted in context.