Macro structures in providing services: mainstreaming, synergism or specialisation

Observations and arguments from the UK, with a focus on experience in Kensington and Chelsea

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National policy and practice background

In England, the macro-organisational of social care in learning disability and indeed for other long term care groups such as people with mental health problems, physical disabilities and age related needs, has been largely defined by the 'health and social care divide' (the separation of agency responsibilities between health organisations and social services departments) and the various approaches to 'joint-working' (largely between health and social services) developed to bridge this divide.

A inhibitor to the early and rapid development of community care in England was that NHS organisations (health authorities) were responsible for the long stay institutions (hospitals), with local authority social services departments responsible for community care. Care in the community (moving people from the long-stay institutions to the community) consequently required joint-working between health and social services organisations and the transfer of funds between them, although in some cases NHS organisations developed their own community care services using nursing models. However, this was against the trend. Individual 'dowry' payments were introduced by the Care in the Community Initiative in the early 1980s (Renshaw et al, 1986; Knapp et al, 1990) to aid the movement of resources and service users across agencies and sectors. Early models of joint-working and joint commissioning emerged as a result (Knapp et al, 1990; Cambridge et al, 1994).

Regional configurations and hierarchies for the NHS and health organisation also contrasted to local government social services departments, variously located with a hierarchy of local government organisations and functions. For example, social services departments are

located in county councils, such as Kent and Somerset, whereas housing departments are a function of a number of different district councils within the same area. London boroughs and unitary authorities have both social services and housing within the same organisation.

Added complications concern the fact that health and social services agencies were also often not co-terminous (they did not cover the same local areas). This was a particularly logistical disincentive to joint working, particularly when considered alongside other differences in organisational culture, service models, management behaviours and professional orientations. Some of these differences still inhibit joint-working today, although recent reorganisation of health authorities into primary care trusts has helped in some places. Another complication is the fact that local government is politically accountable to local people with elected members and professional officers, whereas there is no such political accountability within NHS organisations, apart from that defined through line management relationships and accountability to the NHS Executive (regional structure) and the Department of Health and Government ministers.

A parallel and linked macro-organisational feature of health and social care in England has been the development of 'internal markets' in health agencies and the wider 'social care market', with social services departments responsible for the separation of purchasing from providing in community care (Department of Health, 1989). This evolution happened in parallel to joint working, through an increasing mixed economy of social care in the 1980s leading to explicit social care markets defined through contractual arrangements in the 1990s. Purchasing and contracts are also important in joint working because of the policy to develop joint or

integrated purchasing strategies or 'joint commissioning' (Department of Health 1995 and 1998) in localities where both health and social services agencies retain responsibility for services for people with learning disabilities.

Consequently, from the late 1990s there have been policy instruments designed to regulate and manage care markets, develop quality and cost effectiveness and implement care standards, and again all such initiatives have impacted on joint working agendas. In addition internal health markets and GP fund-holding were abolished with the development of initiatives such as clinical Governance aimed at increasing accountability and quality in NHS organisations and new health structures introduced (Department of Health, 1997).

Alongside these two primary features of macro-organisation have been both higher level demands and lower level responses characterising the implementation gap between national (central Government) policy and local (health and social services) practice. In contrast to the Care in the Community pilot projects, informed by evaluation and linked to demonstration (Knapp et al, 1992, Cambridge et al, 1994 and 2000), *Valuing People* (Department of Health, 2001) was not evidence based, with an implementation task force following the policy. Other policy instruments have been designed to overcome some of the implementation and co-ordination difficulties associated with previous central policy initiatives. Care management came with the 1990 community care reforms (Department of Health, 1992) as a way to help co-ordinate individual services in a complex care market and PCP came with *Valuing People* to help redirect the focus of management and practice onto the individual service user.

Historical resume

Box 1 summarises the historical background to joint working and joint commissioning.

It can be seen that joint working between health and social services has a long record of fragmentation and under-performance in community care for people with learning disabilities, but also that over two decades, similar solutions have continued to be mooted, such as single management and budgets, yet outside a willingness to implement a fundamental reorganisation of community care into single agencies and discrete territories.

Box 1. Established policy rationale for joint commissioning

The Audit Commission (1986) had recommended that local authorities should be made responsible for the long term care of '*mentally and physically handicapped people in the community'* and that *'the resources necessary to do this should be transferred from the NHS' (para. 174.1),* thus recognising the imperative to develop unambiguous lead agency and funding responsibilities. The Audit Commission (1987) also recognised that the needs of people with learning disabilities were rapidly changing as a consequence of de-institutionalisation and new service principles such as Normalisation (Wolfensberger, 1980: 1984) and it was observed that *'Unless local authorities work with health authorities quickly to ensure a needs based allocation of available resources, the totality of services may contract unacceptably' (p. 1).*

'Community Care: Agenda for Action' (HMSO, 1988), added weight to the argument for integrated purchasing and service development, stating *'there must be a clear framework within which local authorities and health authorities are working out their own process of co-ordination. The programme should be matched by parallel approval of those parts of the health service plans allocated and ring-fenced for community care' (para. 23*). In 1989 the Audit Commission took this concept a step further by suggesting joint management of services by health and local authorities with *'a joint manager..... responsible for a jointly funded budget' (Audit Commission, 1989, para. 66),* in other words, local joint commissioning.

The 1990 community care reforms *Caring for People*, (Department of Health, 1989) made little progress in removing the organisational and funding disincentives to joint working. The Audit Commission (1992) re-focused attention on funding by observing that *'Even if clarity of responsibility can be agreed, it must be complemented by ways to adjust finance on a continuing basis' (Audit Commission, 1992, Paras. 20-21).*

The need for robust financial strategies was acknowledged by the 1981 Care in the Community Initiative (Knapp et al, 1992: Cambridge et al, 1994) and the variety of macro-organisational models which emerged. Joint and lead agency services were for example more strategically driven, better managed, more comprehensively designed and better integrated and implemented, than single agency or independent models. Collaborative culture was seen to achieve a range of benefits, including clear mission and co-ordination, familiarity with service models, fewer developmental risks and common development goals, multi-disciplinary working and shared accountability and management responsibility:

> *The slow and uneven development of community care stems in part from fragmentation of responsibility and accountability, horizontally across agencies and vertically between tiers of government. Not surprisingly, the suggested reforms of many commentators, including the Audit Commission, (1986) and Griffiths (1988), included single agency responsibility for client groups, combined with unambiguous funding channels (Knapp et al, 1992, p. 237).*

The longer term follow up of the twelve learning disability services through the period of market and community care reform (Cambridge et al, 1994) also identified major difficulties for working the mixed economy of provision, particularly where local learning disability service strategies did not exist and agency roles and responsibilities were loosely defined. Deficits included inadequate performance monitoring of providers, poorly co-ordinated community care planning, confused responsibility for the performance of care management tasks and fractures in accountability. In a few localities this impacted negatively on

care providers, with some service users returning to institutions (see Camden case study Cambridge et al, 1994).

'Joint commissioning' was introduced as a policy instrument in the early 1990s as an advance on previous attempts at joint planning such as joint care planning teams (JCPTs) and community care planning led by social services (Wistow, 1990). However, its implementation was piecemeal and there were legal constraints, just as there were financial disincentives to the joint finance and joint planning systems in the 1970s and 1980s (Wistow, 1982 and 1983). Approaches reflected local conditions, relationships and priorities and were in part a response to the management demands of developing social care markets. No single model predominated, and with very different management, budgetary and operational arrangements between health and social services, such joint purchasing was described as collaborative purchasing or purchasing in tandem (Wertheimer and Greig, 1993).

Observers also pointed to the lack of agreed definitions for joint commissioning (Hudson, 1995), the weak understanding of function, process and outcome (Poxton, 1994) and the imperative of collaboration where purchasing authorities were too small to develop integrated strategies or lacked the required purchasing skills (Ham, 1992).

Knapp and Wistow (1992) focused on the commissioning process within a model of service development and review, with micro or tactical purchasing also taking place by care managers. This overall process for joint commissioning was later mirrored in the cycle promoted by the Department of Health (1995). Joint commissioning was also defined at this point as:

> *The process in which two or more commissioning agencies act together to co-ordinate their commissioning, taking joint responsibility for translating strategy into action (Department of Health, 1995, p. 3).*

The main block to joint commissioning at this point were legal constraints to pooled budgets and devolved powers of assessment from social services. Implicitly, like joint finance before it, joint commissioning tended to concern small projects rather than wider service strategies. New Labour quickly identified the imperative for joint working, through its commitment to remove the legal blocks to pooled budgets and to promote lead commissioning by a variety of agencies in order to achieve more integrated local provision (Department of Health, 1998a).

Expectations for joint commissioning were high, as in theory it offered a way to help reverse the fragmentation and fractured accountability stemming from contractualism and social care markets (Cambridge and Brown, 1997), reduce the imperfections and distortions in social care markets (Wistow et al, 1993; Le Grand and Bartlett, 1993), develop comprehensive service strategies in learning disability and challenging behaviour (Mansell, 1993) and provide comprehensive and comparable information on service costs and to link this to user outcomes for cost-effective decision-making (Cambridge and Knapp, 1997).

Observers commented on the patchy progress of joint commissioning (Waddington, 1995; Cambridge, 1999a) with the Social Services Inspectorate (1998) highlighting the importance of partnership approaches for creating a single service for people with learning disabilities:

> ….. *responsibilities were diffused, even within the SSD alone, the lack of strategic and coordinating lead was apparent. (Para. 8.6, p. 57),* and
>
> *Organisations seemed most effective with a single manager leading on learning disabilities strategy and commissioning (Para. 8.7, p. 57).*

As outlined above, *Partnership in Action* (Department of Health, 1998a), signalled the Government's intentions to remove the legal barriers to joint working in order to enable three main commissioning models, viz.

?? pooled budgets between health authorities or Primary Care Trusts and social services departments, with the joint budget accessible to both commission and provide services
?? lead commissioners – health authority, Primary Care Trust or social services department – with funds transferred and functions delegated for the commissioning of health and social care
?? integrated provision, with an NHS trust or Primary Care Group to provide social care services or a social services department to provide a limited range of community health services

Yet historic parallels remain evident for the function and operation of joint commissioning in relation to primary care group purchasing (Department of Health, 1997 and 1998a) and service development and

joint working between primary care trusts (PCTs) and social services departments in developing services for people with learning disabilities, such as in Kensington and Chelsea. In some local authority areas, for example, social services may have to work with a number of different PCTs and in Kent, only one of these has lead responsibility for learning disability. Some social services departments have also had to reorganise their divisional structures to coincide with PCTs whereas other have developed overarching strategic links or co-ordinating mechanisms.

Partnership boards (PBs) were set up as the joint-working mechanism between SSDs and PCTs and there are generally specific PBs for each of the different user group. However, PBs have no executive powers, so their success and influence largely depends on the status, authority and commitment of their managerial and political representatives. In Kensington and Chelsea these include senior representatives form health and social services as well as other interests and contribute to the overall local development plan, which is one of the ways the Department of Health determines funding for the PCTs and local services. In addition, joint investment plans (JIPs) have been required of PBs since 2000 and there are JIPs for each of the main user groups for community care.

Joint purchasing and joint working in practice

A comparison of experience in Lewisham and Somerset provides a picture of how varied progress was in the 1990s.

The London borough of Lewisham developed an explicit joint commissioning agency while in Somerset county council social services

department, joint commissioning evolved from a joint health and social service strategy promoted by senior managers in the late 1980s through a clear social services lead. More recently Kensington and Chelsea have developed partnership working between the social services department and the primary care trust based on recently emerging organisational arrangements (see case studies below).

Lewisham

Lewisham Partnership was originally envisaged as semi-independent joint commissioning agency (Wertheimer and Greig, 1993), but now functions as a local purchasing arm of Lambeth, Southwark and Lewisham Health Authority and Lewisham Social Services (without a single budget). The rationale was that Lewisham Partnership would manage the local community care market and close the gaps between authority level funding and the development of individual, needs led services - the health and social care components of services for people with learning disabilities. The mechanisms of a pooled budget, devolved purchasing to care managers, individual service specifications and the break up of large ex-public sector providers into smaller competing not-for-profit organisations were used to close these gaps.

The Lewisham Partnership model represented one of the purest attempts to develop integrated joint purchasing (Greig, 1996: Cambridge, 1996) and came close to the pooled budget model identified by the Department of Health (1998a)

> *Pooled budgets – health (Health Authorities or Primary care Trusts) and social services to bring their resources together into a joint budget accessible to both commission and provide services. This*

> *will make it easier for staff in either agency to pull together a comprehensive integrated package of care of users* (Department of Health, 1998a, para. 2.2, p.8).

However, it met legal constraints at the time (early 1990s) and its operational capacity was restricted by the local auditors (delegating statutory responsibility for assessment and spending to a non accountable body). Although some such legal restrictions have now been removed (Department of Health, 1995; 1998a), other restrictions have continued to undermine the potential of working, particularly the geographical 'hit and miss aspects' and its dependency on the interests and commitment of local managers.

Somerset

It is from creative inter-agency collaboration in the past that productive lessons for future joint commissioning can be found. The account provided of lead agency arrangements for community learning disability services in Somerset (Cambridge et al, 1994) Five years On, provides powerful support for this hypothesis. There was initial agreement on a joint strategy between Somerset Health Authority and Somerset Social Services, with lead agency responsibility for management and operation passed to social services through local consensus and a joint county strategy (Knapp et al, 1992).

As people with learning disabilities moved from the old hospitals into new community services, the health authority was billed by social services, with funds progressively transferred. This necessitated information systems on individual service utilisation and costs and planning for change demanded similar systems on needs and outcomes.

Thus Somerset developed in the late 1980s the sorts of management information systems the Audit Commission was promoting in the early 1990s and by default, a model of joint commissioning close to that now being promoted (Department of Health, 1998a):

> *Lead commissioners – one authority (Health Authority, Primary Care Trust or Social Services Authority) to transfer funds and delegate functions to the other to take responsibility for commissioning both health and social care. This will put the needs of patients and users at the heart of commissioning and eliminate wasteful overlaps and gaps* (Department of Health, 1998a, Para. 2.2, p. 8).

Linked with care management from within social services, this approach began to link strategy and tactics, seen as an essential element of joint commissioning (Knapp and Wistow, 1992), helping avoid the emergence of two tier services. At Twelve Years On (Cambridge *et al*, 2001) new demands for performance management, accumulating resource constraints, an increasingly mixed but managed economy of provision and the progressive divergence in service patterns and standards between divisional structures and budgets in learning disability have led to a service review. The intention is now to move towards a more explicit joint commissioning framework (Somerset Social Services, 1998). A small joint commissioning team developed strategy from community care planning, incorporating the interests of primary care groups and the local NHS provider trust. The tight central steer was balanced by more comprehensive care management through joint multi-disciplinary learning disability teams.

Kensington and Chelsea

The current approach developed in Kensington and Chelsea provides a contemporary model of best practice, although again the point needs to be made that poor practice exists elsewhere. The success of the Kensington and Chelsea approach has hinged on the relationship between Kensington and Chelsea Social Services Department and Kensington and Chelsea Primary Care Trust. The boundaries are co-terminous and the relationship between social services and the PCT has developed and should be viewed in the context of the wider service system illustrated in Figure 1. Figure 2 maps the associated decision making processes involved in this relationship.

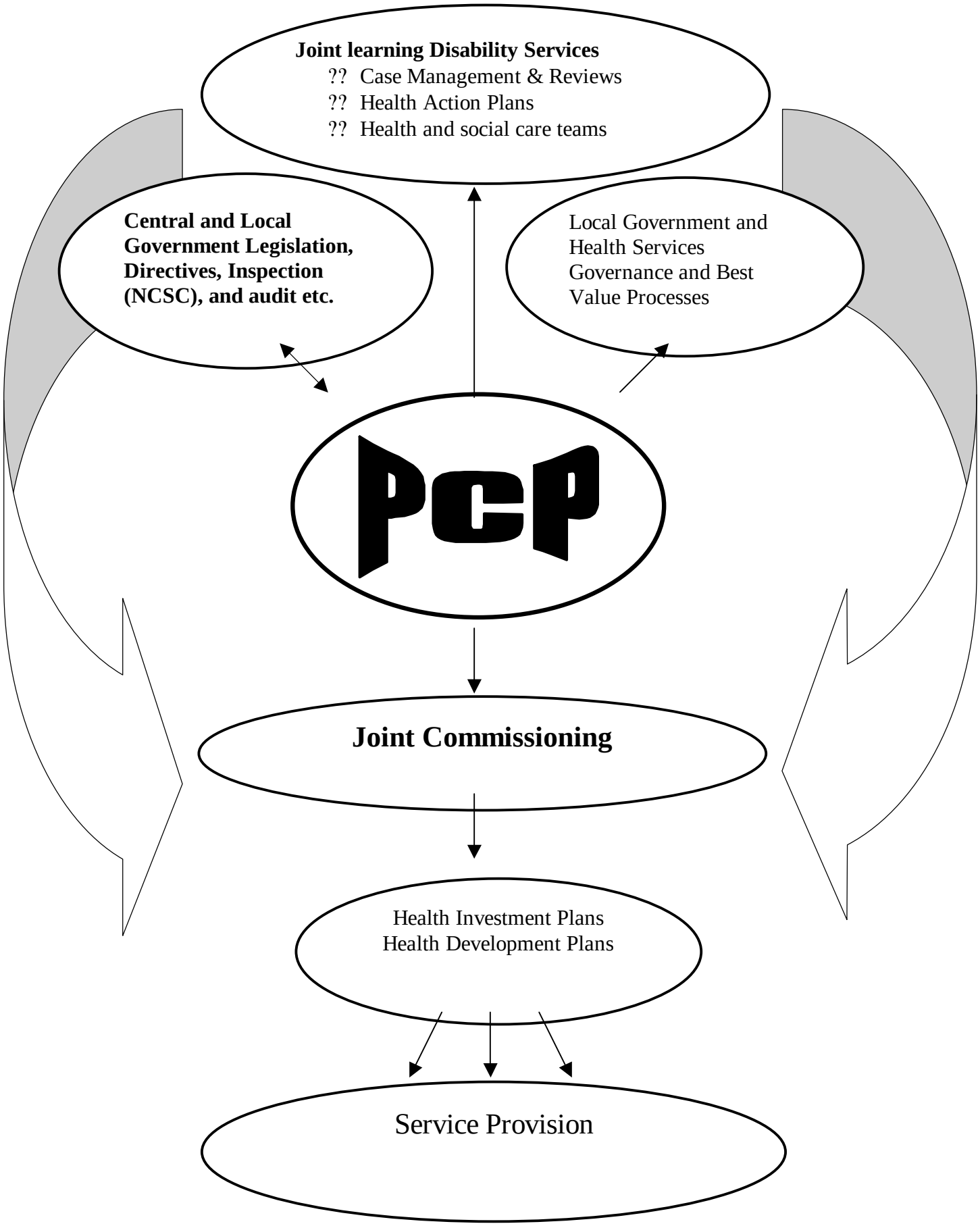
In Kensington and Chelsea the PCT is co-terminous with the RBKC (Social Services Department) which makes for a good basic foundation for joint-working. Indeed, it is recognised that there are economies of scale (in terms of budgets and service user numbers) for planning and commissioning services for people with learning disabilities and Kensington and Chelsea may be at the margins of viability with a £11.5 million budget and a learning disability population of around 400 service users. A similar observation was made by Ham (1992) in relation to locality purchasing. More widely there are also issues of organisational viability in terms of employing skills and competencies in smaller rather than larger administrative units. Partly as a response to such issues, management and operational links have been built with LB Westminster SSD/ PCT to enable the development of complex and often expensive services required by a small number of users in each borough/PCT.

One of the difficulties of current joint-working between health and social services has been investing in and developing good individual working

relationships between senior managers. Health organisations have undergone at least three rounds of strategic reorganisation since the late 1990s, for example Riverside Trust became Parkside NHS Trust which evolved as a part of KC Primary Care Group (PCG) before becoming Kensington and Chelsea Primary Care Trust. In some localities this reorganisation effected working contacts, roles and relationships but in Kensington and Chelsea it proved possible to establish continuity in joint-working at the senior management level. But there remain different management structures and forms of accountability to manage. RBKC is in local government with elected members and officers. Decision-making is through a cabinet system (unlike in some other local authorities where there are member-officer committee structures). This compares to the PCT which is accountable through NHS lines and systems. In Kensington and Chelsea there is the PCT Board, the Management Team (TMTs) and a Professional Executive Committee (PEC) with links to the various Joint Partnership Boards.

Jointness is being promoted in a number of ways at a number of levels across the two organisations. The Joint Strategy for Adults with Learning Disabilities was produced in 1999 to aid joint commissioning arrangements and a Joint Health Partnership Board comprising senior managers, executives and politicians from the RBKC and PCT co-ordinates the work of the various other PBs, including the Learning Disability PB and its £11.5 million JIP / budget. The Royal Borough of Kensington and Chelsea, being a three star authority does not however have its client group budgets ring fenced (protected) so the LDPB has to make a strong case for its spending needs. Jointness is further promoted through the activity of commissioning and contracting and through assessment and care management (in the joint team) and in provisions (of day, respite and residential services).

Figure 1. The local service system in Kensington and Chelsea



Include Figure 2 here

Decision making processes for joint services in Kensington and Chelsea

Social care markets

The other main macro-organisational divide in social care in Britain has been the social care market since its introduction in 1990, which can be seen as a political attempt at deregulation. There followed a series of attempts to intervene, manage and regulate this market in the late 1990s and early 2000s under New Labour. During a period of over 10 years however, a divide has undoubtedly opened up between purchasers (health and/or social services) and service providers and by default service users who were mostly left outside contractual relationships. (Cambridge and Brown, 1997; Churchill, 1992).

Providers were initially located in a mixed economy of public, not-for-profit and local and national voluntary organisations, but the development of the market has in some places seen the 'privatisation' and floating off of public sector provision through the use independent trusts and increased private and commercial sector provision, as well as the use of paid home care providers. This has tended to shift the market to a reliance on low paid, de-unionised and un-priced (informal) care (Cambridge and Brown, 1997) characterised by short term planning and development horizons and just-in-time production.

The 1990 community care reforms *(NHS and Community Care Act)* redefined the responsibilities and functions of the public sector agencies, mainly in relation to social services lead responsibilities/ agencies for community care planning, care management and purchasing, with purchaser provider relationships redefined around contracts. There was no device to specifically help integrate frequently diverging purchasing strategies between health and social services locally or indeed between

different local authorities or health agencies, generating sometimes acute implementation gaps (Lewis et al, 1995) and increasing inequities between authorities (Cambridge et al, 1994).

The emerging care market also worked against other aims as it often challenged the capacity of the public sector agencies to manage change and deliver integrated and comprehensive community care (Forder et al, 1996). The contract varied from block to cost and volume and individual contracts and from authority wide to locality purchasing, depending on internal organisational structures, but all forms tended to perpetuate user exclusion and worker marginalisation (Cambridge and Brown, 1997). Devolved budgets and accountability, with purchasing by care managers (where it was happening), was also tending to generate tensions between tactical and needs led purchasing and strategic direction (Knapp and Wistow, 1992).

There was also a preoccupation in health agencies in the early 1990s with developing GP fundholding and internal markets (both since abolished). The interest in the market and indeed care management, which was also seen as a device to co-ordinate services across agencies and sectors, perhaps reflects not only a political dogma on the part of the then central Conservative administration, but a fear to radically reorganise responsibilities for health and social care into single integrated local agencies.

New labour also adopted a quick fix approach. Rather than radical reorganisation it introduced a wave of new policy instruments designed to manage and regulate markets, rather than abolish them, such as best value and care standards (Department of Health, 1999; Cambridge, 2000), which promoted quality standards, user and provider consultation and cost

effectiveness. In parallel, new values and expectation were being imposed through initiatives such as *No Secrets* in adult protection (Department of Health, 2000a) and in the *Valuing People* learning disability strategy (Department of Health, 2001).

Broader issues for macro-organisation

It is easy to ignore less visible issues in learning disability within this changing macro-organisational context. Challenging behaviour is for instance, an example of the potential for joint commissioning to respond to a critical policy and practice theme and an important area of generally unmet need (*Facing the Challenge*, King's Fund, 1987). Specialist providers and professionals from health have generally retained responsibility for people with learning disabilities who challenge services, particularly those moving from institutional care - community support teams for people with learning disabilities and challenging behaviours are usually health funded and led by psychology services (Emerson et al, 1996: Forrest *et al*, 1995). This is despite the central policy recommendation that commissioners take a strategic view of challenging behaviour and purchase services based on individual needs (Mansell, 1993).

It is also a good example for the conflicting tensions between specialist and mainstream competence and segregation and integration in learning disability services, as argued by Mansell (1993). However, mainstreaming also and perhaps more importantly refers to issues of integration between specialist learning disability services and services more widely in the community, particularly work, leisure, education, housing and health. These were all signalled by *Valuing People* (Department of Health, 2001)

as being important in relation to helping achieve the policy aim of social inclusion.

Yet we know of the strong evidence across such domains of the barriers and difficulties experienced in mainstream access by people with learning disabilities, despite important progress through integrated development strategies. Poor health outcomes, with inadequate access to GP and dental services through the NHS (see for example discussion in *Tizard Learning Disability Review* Vol. 8, Issue 2, 2003), the need to facilitate access to mainstream education and transition into adult services (see for example discussion in *Tizard Learning Disability Review* Vol. 5, Issue 4, 2000) and access to housing services through other local government departments and voluntary housing associations remain as importance areas of improvement, despite examples of local innovation and best practice. Such issues require a joint-working web across tiers of local government, different local agencies, sectors and divisions within local public sector organisations.

Particularly challenging areas include mental health and dual diagnosis (people with learning disabilities and mental health problems – see *Tizard Learning Disability Review* Vol. 4, Issue 2, 1999) and older people with learning disabilities, for which there has been a national research programme funded by the Foundation for People with Learning Disabilities (see *Tizard Learning Disability Review* Vol. 7, Issue 2, 2002). These two areas of course come together for older people with learning disabilities, particularly those with Down's Syndrome, and dementia, with many learning disability services currently exploring the relationships between and problems and potentials of specialist and mainstream services.

Access to mainstream housing for people with learning disabilities remains difficult in some localities and limit the development of supported living. In other areas good working relationships have been established between learning disability services and special needs housing associations and mainstream public housing. In Kensington and Chelsea however, the housing department is under immense pressure as an inner London Borough, particularly from its statutory responsibilities for refugees and asylum seekers, single parent families and wider demands generated by local property prices and the lack of affordability of purchased and privately rented accommodation.

Health is the other key area for improvement, signalled also by the Government through local Health Action Plans. In Kensington and Chelsea, piloting work is being undertaken with a number of General Practitioners (GPs) to improve access for people with learning disabilities and Health Action Plan information has been provided in accessible format to people with learning disabilities and their carers.

The imperative of individualisation

It is easy for attention in debates about meta-structures and macro-organisation to be distracted from the fundamental and primary interests of service users. Indeed, policy-makers in Britain have over the last twenty years paid more attention to the former than to the latter. After all, Care in the Community and de-institutionalisation was less to do with individualisation than it was to do with care principles, philosophies of care and accompanying political (and largely mistaken economic) imperatives.

There remains however, a real underlying tension to the organisation of community care between the macro and strategic and the micro and individual. Care management was introduced in the 1990 community care reforms as a policy instrument to help develop individual care packages but also to co-ordinate services across a mixed economy of care, thus bridging macro- and micro-organisational demands. More recently there has been the reversal of the shift from the centre to the periphery in the 1990s, with devolved budgets and authority, to greater centralisation and regulation, typified by care standards and the National Care Standards Commission (Department of Health, 2000b) and the establishment of national bodies charged with developing excellence in health and social care (Commission for Health Improvement CHI and Social Care Institute for Excellence SCIE respectively). A new Training Organisation for Social Care (TOPSS) has also been established and existing bodies such as the Social Services Inspectorate and Audit Commission remain.

Yet there is the counter shift to the individual through direct payments (Nuffield Centre, 1998), with the increasing probability that social care resources will bypass agencies, managers and professionals (Holman and Collins, 1997) and place greater economic power directly into the hands of service users and carers. However, public accountability still needs to be retained and safeguards put in place to protect professionals and service users.

The STEPS partnership is in a position to report and co-ordinate the work which is being undertaken in Kensington and Chelsea to ensure a link and mesh in operation and values between PCP and systems of joint working as well as other systems such as care management, advocacy and direct payments. In relation to PCP for example, Paul Swift from the Institute of

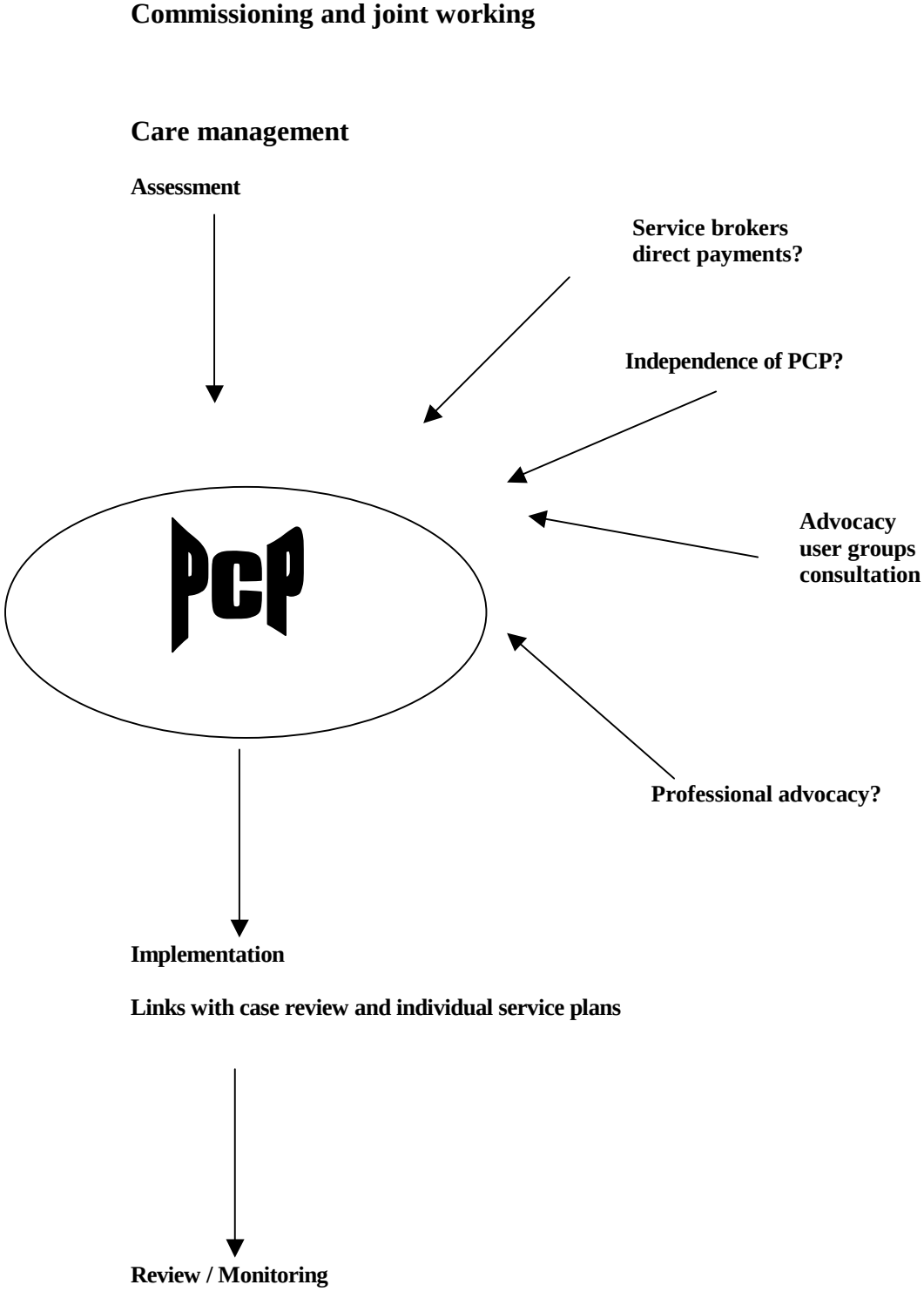
Applied Health and Social Policy at King's College London, is evaluating PCP in Kensington and Chelsea and Westminster. Department of Health guidance places a responsibility on Learning Disability Partnership Boards to ensure that PCP is implemented through Local Implementation Groups (LIGs). The evaluation would aim to determine the effectiveness of initial plans and identify further development requirements, with a focus on users with complex needs.

Other considerations regarding the implementation of PCP link strategy to tactics. The interim experience suggests PCP is intensive of time, energy and resources and may be overly optimistic regarding user networks and staff support available to translate user preferences into outcomes without introducing their own agendas. Additional training and support is needed as it is naïve to assume that staff in provider organisations will understand the process of PCP and their potential role in it. Moreover, for any bureaucratic organisation it is not easy to toss aside history and tradition in responding in user centred ways. Similar structural problems exists around direct payments and take-up. Integrated records and notes help, but users do not want this and it is also evident that other user focused work such as in care management has often not met its aims.

In relation to care management, PCP also need to link in and integrate with existing individual service planning arrangements and the care management review, which includes service providers. Figure 3 illustrates such links. Just as commissioners need aggregate information form care planning to inform commissioning, they will need information from PCP. User expectations are low because of restricted choices in the past and commissioners will need to disband many existing arrangements and

service configurations. Staff also need to feel safe and valued in such a change environment and we need to develop more organic organisations.

Figure 3. Connections between PCP and other micro and macro systems



Observations and conclusions

Some of the fundamental non-legal barriers to joint working, particularly the potential for territorial discontinuity and disconnection between agencies remain to be addressed. In many localities, joint commissioning and joint working would be a virtual logistical and organisational impossibility, due to non-coterminous public sector agency boundaries and area divisions. This seems particularly the case in England, where health and social services agencies remain separate organisations with different systems of public, management and political accountability (whereas in Northern Ireland and Scotland for example there are joint health and social services boards covering particular areas). The common solution promoted for over 20 years has been joint budgets, yet this remains a permissive option. However, in practice success seems to hinge as much on management attitudes and commitment in the respective agencies as on other aspects of jointness.

The apparent 'randomness' of successful joint-working, but particularly the question of organisational fragmentation in some localities, raises the theoretical prospect of special learning disability commissioning agencies for defined territories, with learning disability budgets ring fenced and management representation transferred from the different agencies involved locally. Semi-independent agencies have indeed been argued in the past for care management (Cambridge, 1999b), although such attempts have failed because of their very independence from the public agencies. Yet a similar dilemma remains to be resolved for managing direct payments and as access and take-up of individualised funding developed the public sector agencies will progressively have resources siphoned out of service budgets,

risking a slide towards a welfare administration and regulation role from a strategic planning and commissioning role.

Although care management has the potential for the development of semi-independent professional advocacy and micro-purchasing, professionals working to such models often report compromise and conflict with their accountability to the funding agency, namely the social services department or joint commissioner (Greig *et al*, 1996). Similar role ambiguity and conflict could surface with direct payments and the service brokerage role, whether from within or outside the public sector agencies. But there remains the potential to build management walls between care management and funding functions within agencies to maximise benefits and potentials and minimise risks and conflicts of interest.

Such factors need to be considered against the back-cloth provided by the condition and characteristics of the local social care markets. These vary markedly from carefully managed models such as in Somerset, to commercially oriented approaches such as in Kent, where care managers micro-commission and localities macro-commission from a range of commercial providers (Cambridge, 1999b). Yet the extent to which central policy initiatives such as best value, regulation and care standards will affect the variability of approaches and reduce inequities (access, eligibility and quality) between authorities and localities in services for people with learning disabilities remains to be ascertained.

Efficient joint strategic working will consequently need to be both structurally efficient and intelligent unless undue administrative or transactional costs are to arise. It will require integration with wider management information and regulatory systems, otherwise its costs could

well outweigh the efficiency savings it could bring to authorities through single structures, the delivery of improved user outcomes or reduced service costs.

As new approaches to joint commissioning and joint working emerge, there is a pressing need to evaluate and review their relative effectiveness in relation to process outcomes, intermediate service outcomes and final outcomes for service users. Micro-organisational systems such as care management and PCP clearly have a place in determining user outcomes and should be seen as part of these wider joint systems and their review. Despite a huge array of intervening variables, it will remain critical to have demonstration information on success and failure in order to inform the implementation and review of joint working arrangements locally and the different models of PCP and individualisation, including direct payments that are being developed.

Individualised information systems on needs, costs and service utilisation will consequently be essential for such approaches (Cambridge, 1996 and 1999a). Individualised costs need to be constructed by commissioners according to the principles of comparability and comprehensiveness (Knapp and Cambridge, 1996) in order to reflect the reasons for cost variability between individuals and services (Knapp and Beecham, 1990). Tactical purchasing and direct payments as well as care management and PCP need agreed access to individual information systems.

PCP within or alongside care management and self-advocacy (and other person centred approaches) provide a raft of tools to combat top down systems and power structures. However, professional and administrative hierarchies also require reorganisation around individualisation to avoid

inefficiencies and resources being raided from service users. This has proved difficult for both care management (Cambridge, 1999b) and PCP (Mansell and Beedle-Brown in press), with the risk that new systems are simply bolted onto old ones or old systems simply renamed (old wine into new bottles syndrome). For example, in developing PCP some local authorities have looked towards existing individual service, care or life planning arrangements as models for implementation just as some care management systems were bolted onto existing community learning disability teams or social work functions.

While person centre planning comes at the bottom of this paper, it does not mean that it is the least important element of the above argument. The case for individualisation has been made and is undoubtedly strong. PCP (Department of Health, 2001) essentially underpins this and much else in the operation, development and review of the productivity of wider organisational systems and the macro-structures which help define them. If individual needs, wants and participation does not lead to person centred services then the superstructures of service organisation will ultimately be unjustifiable and unsustainable.

Figure 4 summarises the components and connections within an integrated local strategy and commissioning structure for services for people with learning disabilities in which service users are included and which links macro and micro-organisation. From this idealised framework and the above discussion the key components of an intelligent service system which integrates elements of macro and micro-organisation would be as follows:

?? User involvement at all levels and in all functions, underpinned by self and citizen advocacy
?? Integrated (joint) strategic service planning and development (commissioning) locally
?? A single (pooled) budget, ideally ring fenced and with responsive resource allocation mechanisms
?? A single management structure for learning disability services locally
?? Integrated care management within the context of multi-disciplinary / specialist team working
?? Individual service planning and person centred planning arrangements
?? Use of individualised budgets and availability of direct payments
?? Individual service specifications and contracts
?? Information system on individual service costs and needs
?? Aggregated information on service costs and needs for strategic commissioning

Kensington and Chelsea is in the position of having most of these elements in place through the hard work of managers, professionals and service users in a variety of public sector organisations and communities of interest. Where elements are not fully developed work is underway to ensure that new systems and frameworks are in place and run effectively. The organisational system is fluid and multi-faceted and reflects the sometimes competing demands, pressures and tensions created by central government policy, local management and professional priorities and practices and user interests from a diverse and multi-cultural community.

Figure 4: The Components and Connections of a User Centred Learning Disability Structure Linking Macro and Micro organisation

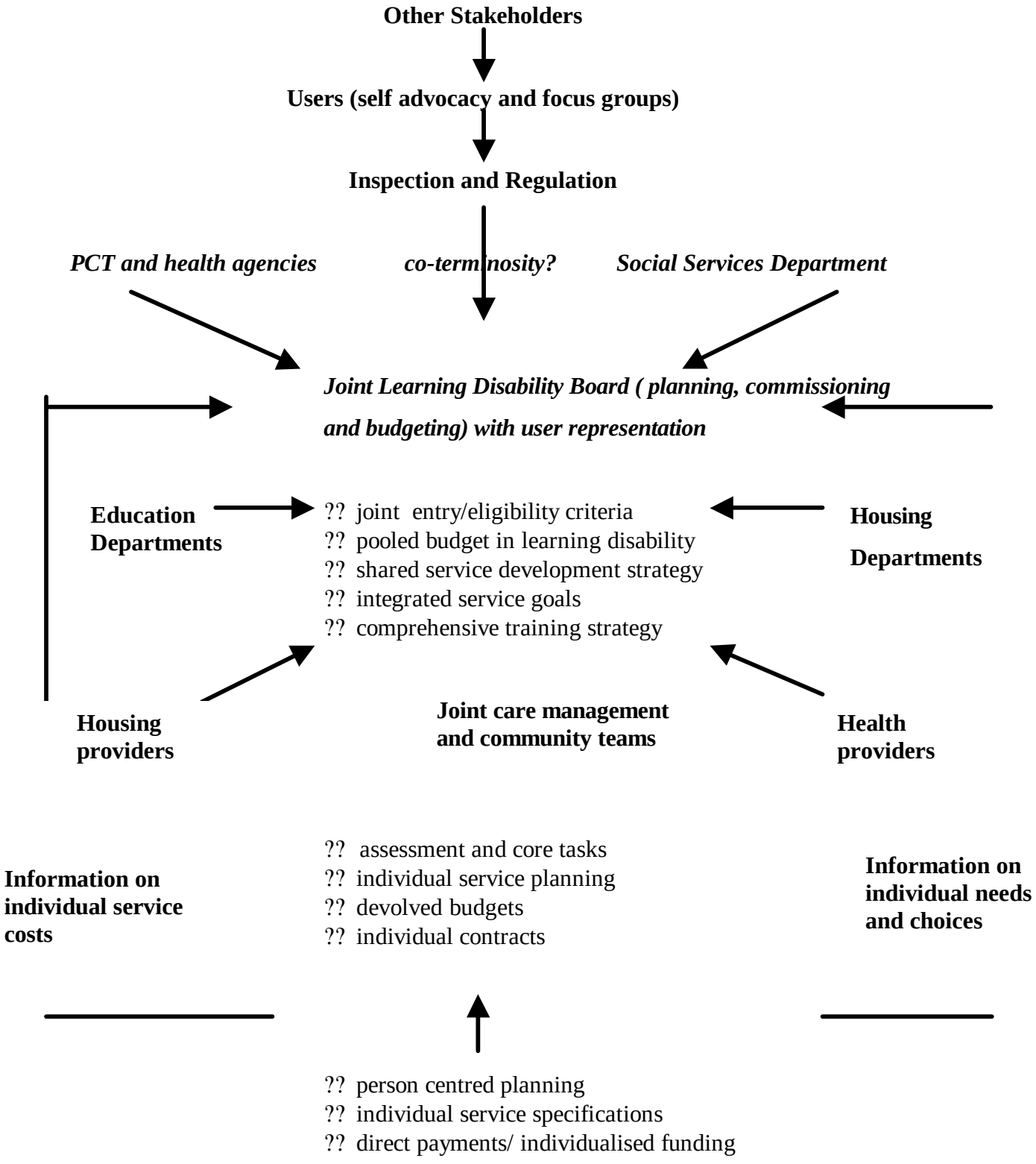


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Figure 2. Decision making processes for joint learning disability services in Kensington and Chelsea