Social Care Governance

A report commissioned by SCIE for the joint project with the
Northern Ireland Clinical & Social Care Governance Support Team

by

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Social Care Governance report to SCIE

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Summary Report

Introduction

1. Social care governance is one of many forms of the term ‘governance’. The use of governance ideas is expanding and brings with it a range of meanings and many expectations, eliciting both optimism and misgivings.

2. At the service level in health and social care, the history of governance is linked to attempts to respond to things that have gone wrong, or may go wrong, or that have not gone sufficiently right. But governance is also about the desire to learn from adverse experiences and, increasingly, to learn from what has gone right and been done well. The aspiration of governance at its best, is to make things better; its commitment is to improve services.

3. The purpose of this report is to contribute to the production of learning materials by addressing sets of key questions intended to explain a concept of social care governance that is relevant at practitioner level and also organisation-wide (corporately) in Northern Ireland’s Health and Social Service Trusts. It is anticipated that the learning materials will be applicable also to the Northern Ireland Guardian Ad Litem Agency. The report pursues its purpose in four ways:

1. the exploration of social care governance and related concepts
2. the development of a useable framework consisting of a) a model of social care governance and b) an outline of a social care governance system
3. the identification of a wide range of written materials available in hard copy or on the internet that are relevant to learning about social care governance and the application of the model
4. the formulation of the social care governance model in sufficient detail to enable future practice examples to be identified and used to illustrate its structure and content.

4. The idea of social care governance is relatively new and does not represent an already articulated body of knowledge. This report is accordingly concerned with the discovery, transfer and analysis of knowledge and the construction of links, rather than with the review of an established domain.

The recent Northern Ireland governance background in brief

5. The development of governance ideas in statutory health and social care in the UK has gained momentum from the New Labour Government’s commitment to ‘modernise’ the public sector but there is a broader spectrum of influences, which includes:

- specific and serious failures of service and professional practice in health and social care and, more generally, unacceptable variations in standards

- a growing commitment under successive governments to place the needs of, and responsiveness to, service users and carers at the centre of policy and practice

- persistent concerns about the proliferation of unelected public bodies (‘quangos’) and inadequately-regulated public officials and politicians

- the judgement that alarming financial failures and irregularities in commerce were a warning for the public sector

- the emergence of the quality movement

- a perception that modern health and social care must be understood and managed as ‘whole systems’ and require partnership to make them work effectively

6. Since 2003, all bodies sponsored by the Department of Health, Social Services and Personal Safety (NI) have to provide formal assurances that they have effective systems of internal control in compliance with core controls assurance standards on governance, finance and risk.

7. Risk is an important, recurrent and sometimes controversial governance theme.

8. Quality was brought to the fore in 2003 by a ‘statutory duty of quality’ given to health and personal social services (HPSS) Boards, Trusts and Agencies. The subsequent consultation on the *Quality Standards for Health and Social Care* provided an explicit vision of the standards that the ‘statutory duty’ must meet (DHSSPS 2005).

The goal and duty of quality

9. Analysis of the *Quality Standards* provides a working interpretation of the statutory duty of quality, which means striving to ensure that:

- *care outcomes* are *effective* in meeting expectations of
    - service users and carers
    - agency objectives and social care values and codes

- *care experience* (process) is *effective* in meeting expectations of
    - service users and carers
    - agency standards and social care values and codes

- *care practices* are *safe* for
    - service users and carers
    - staff
    - the public

- *service users* and *carers* are *involved*

10. Quality provides the core concept on which the model of social care governance is built in the report. It is characterised by *effective care, safe care practices and involvement.*

The nature and dimensions of governance

11. Governance ideas come in a wide and sometimes confusing range. The idea can also seem remote from the front-line world of social care and prompts some practitioners to ask, where is the connection?

12. The connection is in the idea of *social care governance* which represents a way of connecting the *professional* and the *organisational* and of binding them in a common enterprise.

13. Social care staff may feel distanced from governance by the term's association at the 'practice' level with 'clinical' matters. However, it is possible by adapting language to suggest some common elements for clinical and social care governance.

14. As well as common ground between clinical and social care governance, there are also elements that social care itself can bring to practice governance:

- a social model of problems
- an understanding of the socially constructed dimension of problems
- a non-traditional, user-involving model of profession
- practice models underpinned by collaboration and partnership
- experience of participatory and empowerment research
- established codes of ethics and practice that foster
    - equal opportunities, anti-discrimination and respect for diversity
    - partnership with service users and carers
    - partnership with other professions and agencies
- understanding of the role of effective line-management and organisational accountability
- developed methods for supervision

15. The imagery of governance is managerial not professional or lay; while *clinical* governance sounds medical and managerial. Social care governance needs imagery with which staff can identify professionally.

16. The required imagery is offered by the idea of a ‘quality service’ as the core concept for this report with its elements of: *effective care and safe and involving care practices.*

17. The goal of quality offers a unifying objective around which a compact on governance may be forged not only with staff but with service users and carers too.

18. Building on this aim, the report outlines *four essential elements* of a model of social care governance for elaboration later:

- engaging with key stakeholders
- assuring quality and accountability
- professional and organisational learning
- leading, managing and participating

19. The development of model of social care governance matters because it represents:

- systematic and serious efforts to achieve a high quality service
- a commitment to place service users and carers at the heart of policy and practice
- an endeavour to connect health and social care systems and to value and use partnership to make them work effectively
- the contribution of social work and social care expertise to the enterprise of responsive, user-centred and carer-centred, effective and safe health and social care services.

Values, ethics, codes and social care governance

20. Values are a driving force both in governance and in social work and social care. They underpin governance in Northern Ireland through the medium of *The Quality Standards for Health and Social Care* and via the *Northern Ireland Act* 1998, which requires public authorities to promote equality of opportunity.

21. There are three sets of codes particularly associated with social work and social care practitioners.

- The Codes of Practice for Social Care Workers and Employers
- The Code of Ethics of the British Association of Social Workers
- The UK National Occupational Standards for Social Work: values and ethics statement of expectations

22. The codes are influenced by, and contain, three streams of values:

- a *traditional stream*
- an *emancipatory stream*
- a *governance stream*.

23. The three streams have points of congruence and of tension where their goals may conflict. Such value tensions are a fact of organisational life and have to be negotiated by the managers and professionals involved in trying to operate governance systems.

24. The values expressed in the *Quality Standards* state that the right governance structures and processes are only part of the equation, and are secondary, in securing a quality service:

> The most important premise is that “service users and carers [should] be fully valued by HPSS staff” (DHSSPS 4/2005 p.6).

Core and enabling quality standards and a model of social care governance

25. Analysis of the main ‘themes’ of *The Quality Standards* underpins the definition of a quality service in this report and informs the model of social care governance that is devised. The analysis does this by dividing the ‘themes’ into two groups: core themes or goals, and enabling themes or means.

26. The core theme of ‘safe and effective care’ is central to the definition of a quality service which is taken here to be the goal of social care governance. A quality service is defined as: *effective care and safe and involving care practices.* Most other themes in the *Standards* are taken as ‘enabling’, that is, as means for achieving the quality service and are fundamental to the social care governance model.

27. The model for social care governance is built by combining the key characteristics of a quality service - *effective care and safe and involving care practices* - with the ‘enabling’ elements, as outlined below.

28. *Core elements of social care governance: delivery of quality care services*

- Core goals of a quality service to users and carers: effective care outcomes and experience; safe care practices; and user and carer involvement

- Modality or style of quality services: the service is values-based, person-centred, community centred, equalities aware and resource-aware in service planning and service delivery.

29. *Four enabling elements of social care governance*

Enabling elements represent sets of structures, procedures, practices and values, which serve the core elements. Four enabling elements are identified:

- engaging with key stakeholders

- assuring quality and accountability

- professional and organisational learning

- leading, managing and participating

30. The four enabling elements of social care governance contain sixteen sets of governance activities that are elaborated and explored in the report. The four elements represent a continuous cycle of activity and learning.

31. Putting the model into practice involves first, the *formal structural aspects* for managing and administering governance; and second, *relational aspects* involved in engaging with governance, participating in it and working with others to improve it. It is essential not to neglect the relational aspect.

32. The third element, *professional and organisational learning,* underlines that learning is key to effective governance.

33. The fourth element, *leading, managing and participating* encapsulates design, planning, the use of learning and acting on what is learned. The activities are also critical in seeking to engender a quality culture and in securing resources.

34. To summarise, the model of social care governance developed in this report is composed of:

- core elements (quality goals)
- enabling elements (four elements and constituent activities)
- a continuous activity-and-learning cycle

Social care governance roles and responsibilities in Trusts

35. The four elements of the social care governance model provide an agenda for governance roles and responsibilities at *all* organisational levels, namely:

- strategic
- intermediate
- operational

36. Each level has its own responsibilities for:

- engaging with key stakeholders
- assuring quality and accountability
- professional and organisational Learning
- leading, managing and participating

37. A role blueprint is not offered. There is no evidence of ‘one best way’ of organising. The precise nature of the roles and responsibilities vary according to organisational level and to local structures and changing circumstances.

Leadership, change and the social care governance system

38. Leadership is a significant component of the social care governance model. It is a function that may be taken by a variety of people in the governance arrangements. However, senior people are uniquely placed in the effect they can have in setting the direction and pace of change, in determining the model and methods of governance and in shaping the governance culture.

39. Research-based suggestions for organisational leaders in developing social care governance arrangements include:

- create clear frameworks
- pace change at the appropriate rate
- identify champions of change
- pilot approaches and share the results across the organisation
- invite small groups to develop or test methods
- make strategies as open, transparent and inclusive as possible

40. Leaders should ensure that the governance model:

- is realistic
- is meaningful
- is professionally-aligned
- is focused and efficient
- provides feedback
- is asset-focused as well as deficit-focused
- is risk-aware not risk-averse
- is learning-oriented not blame-oriented
- sustains credibility and involvement
- demonstrably supports quality objectives.

41. The quality-focused model developed for this report aligns with important injunctions of the *Controls Assurance Standard for HPSS on Governance* and also connects directly with the statutory duty of quality.

42. The report concentrates particularly on social care governance as a *model*. But social care governance is not only a model. It is a set of *aspirations* to an improved, accountable, involving quality service. Realising those aspirations depends on harnessing a multiplicity of components that take the analysis beyond any single model of social care governance towards a social care governance *system*.

43. The research for the report has identified seven components of a social care governance *system*:

- a model of social care governance
- social care values
- the imperatives of government policy
- a quality and learning culture
- human and other resources
- a supportive infrastructure
- a strategy and style for implementation

44. The transformation of these components into a social care governance *system*, depends on the actions of organisational leaders and policy-makers at central, regional and local levels, but it also implicates participants system-wide, that is, within the organisation and beyond its increasingly fluid boundaries. The task is to connect the different components and to do so in a way that is visible to all involved.

Social Care Governance

Introduction

Social care governance is one of many forms of the term ‘governance’. The use of governance ideas is expanding and brings with it a range of meanings and many expectations, eliciting both optimism and misgivings. This report will discuss later some of the different ways in which governance is defined and pursued and where the idea of social care governance sits in the constellation. It is important at this beginning point, however, to step past the mystification that sometimes accompanies the use of the word governance, to register the aspirations common to ideas of governance in health and social care.

Governance operates at many levels. At the service level in health and social care, its history is linked to attempts to respond to things that have gone wrong, or may go wrong, or that have not gone sufficiently right. This legacy can associate governance with defensiveness, and that aspect will be discussed, but governance is also about the desire to learn from adverse experiences and, increasingly, to learn from what has gone right and been done well. The aspiration of governance at its best, is to make things better; its commitment is to improve services.

The purpose of this report as set by the commissioners and partners is:

> *to contribute to the production of learning materials by addressing sets of key questions intended to explain a concept of social care governance that is relevant at practitioner level and also organisation-wide (corporately) in Northern Ireland’s Health and Social Service Trusts.*

It is anticipated that the learning materials will be applicable also to the Northern Ireland Guardian Ad Litem Agency. The key questions fall into six groups that were interpreted as setting an agenda for the research for the report, as follows:

- what are the nature, dimensions and relevance of social care governance? (addressed particularly in sections 1-3)
- what are the contributions of service users and carers to social care governance? (various sections of Part 3)
- what is the relevance to social care governance of social care values, standards and codes? (section 4)
- what kind of model of social care governance would align with social care values, Northern Ireland policy expectations and the work of Health and Social Service Trusts? (various sections of Parts 2-4)

- how does such a model link with established organisational and professional practices and with training and learning? (Part 3)

- what are the implications of the model for roles and responsibilities across a Trust? (Parts 3 and 4)

These questions set the terms of the information-gathering for the report. Responses to them are woven into the body of the report where they are used to build a model of social care governance. The report contributes to the goal of producing learning materials in four ways:

1. the exploration of social care governance and related concepts

2. the development of a useable framework consisting of a) a model of social care governance and b) an outline of a social care governance system

3. the identification of a wide range of written materials available in hard copy or on the internet that are relevant to learning about social care governance and the application of the model

4. the formulation of the social care governance model in sufficient detail to enable future practice examples to be identified and used to illustrate its structure and content.

(please see *A Note on Examples…* at the end of this Introduction).

The chief sources of information are as follows:

- SCIE literature-scoping reports

- detailed literature searching, including web-searching, by the consultant

- Northern Ireland policy documents and working documents

- advice and expertise of the Northern Ireland Clinical and Social Care Governance Support Team

- focus groups with
    - service users and carers in Northern Ireland
    - front-line practitioners from the Health and Social Services Trusts
    - first-line and middle managers from the Health and Social Services Trusts

- advice and expertise of the Project Steering Group

- consultation with governance experts in the fields, respectively, of health, social services, higher education and governance research.

Governance represents a wide and developing territory of ideas, objectives and methods. It has recurrent features relating to accountability, risk, quality, and stakeholders but the work for this report found no unarguably best way of representing or organising governance. Both require choices and interpretation. Accordingly, the approach in this report represents a set of interpretations based on the research and analysis undertaken in the project of a large number of sources. Many of those sources are cited in the text and referenced in each section while numerous others are available separately in the "Bibliography of additional of works consulted…" (Appendix 2)

The report does not attempt to be the final word on social care governance. The sphere is still too new and dynamic for any such thing. The report aims to be a contribution to an important and developing sphere at a stage when the task is more to do with the discovery, transfer and analysis of knowledge and the construction of links, than with the review and reporting of an already articulated body of knowledge in social care governance. As such, it seems far closer to the beginning of a process than to its conclusion.

Terminology

The use of some terminology needs to be clarified. First, the terms 'social care' and 'social care and social work' are both used in the report. The usage has been explained as follows (Whittington and Whittington, forthcoming):

The code of practice issued by the four UK national care councils applies the term social care to embrace both social workers and the greater numbers of other staff providing social care services (NISCC 2002). Social care is also the term applied to the services that social care staff provide, a synonym for social services. Social care is, thus, both a set of services and the workforce providing those services. The dual convention is followed in the Report of speaking of the workforce collectively and, when necessary, of distinguishing between social work, as a distinct occupational group with a particular history and qualification, and the wide variety of other social care staff.

Secondly, the terms profession and professional are used widely in the report. They are not used to denote status or distinguish qualifications but are a collective shorthand for all those occupations providing and commissioning social care and social work services.

A note on examples from policy and practice

Staff of H&SS Trusts were invited to provide illustrative examples relevant to social care governance for possible use in the planned SCIE resource guide. The project timescale did not give time for volunteered materials to reach the project team for review and translation into suitable form for inclusion in the present report. Those materials are being gathered and some are mentioned briefly in the report. In the meantime, two examples from materials collected from outside Northern Ireland earlier in the project are included for illustrative purposes.

References: Introduction

NISCC (Northern Ireland Social Care Council) (2002) *Code of Practice for Social Care Workers*, Belfast: NISCC.

Whittington, Colin and Whittington, Margaret (forthcoming) "Ethics and Social Care: political, organisational and inter-agency dimensions," in *Ethics: Contemporary Challenges in Health and Social Care*, A. Leathard and S. McLaren (eds), Bristol: Policy Press.

Part One: Quality, Governance and Values

1. The recent Northern Ireland governance background in brief

In 2003, a statutory duty of quality was given to health and personal social services (HPSS) Boards, Trusts and Agencies by the *Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order* 2003. Two years later, the consultation on the *Quality Standards for Health and Social Care* provided an explicit vision of the standards that the statutory duty must meet (DHSSPS 2005a). The *Standards* were the culmination of a series of developments that laid the foundation for governance of health and personal social services (HPSS) in Northern Ireland.

The development of governance ideas in statutory health and social care in the UK has gained momentum from the New Labour Government's commitment to 'modernise' the public sector, strengthening effectiveness and efficiency (RPA Team 2005) but there is a broader spectrum of influences. Influential factors include:

- specific and serious failures of service and professional practice in health and social care and, more generally, unacceptable variations in standards
- a growing commitment under successive governments to place the needs of, and responsiveness to, service users and carers at the centre of policy and practice
- persistent concerns about the proliferation of unelected public bodies ('quangos') and inadequately-regulated public officials and politicians
- the judgement that alarming financial failures and irregularities in commerce were a warning for the public sector
- the emergence of the quality movement
- a perception that modern health and social care must be understood and managed as 'whole systems' and require partnership to make them work effectively

The first in the list, serious service failures involving injury or death of service users and harm to members of the public have been a recurrent source of efforts to change, correct and improve organisation and practice in the public sector in the UK over many years. Trust was undermined both in the services and in the self-regulation of professions who staff them. Examples include, in health, the Shipman murders and infant mortality in cardiac surgery at Bristol Royal Infirmary and, in social care and health, the manslaughter of Jonathan Vito and the death of Victoria Climbié (Ritchie 1994; Secretary of State for Health 2001; Secretaries of State 2003; Smith 2004).

In Northern Ireland, the death of David Briggs and the injury to his brother Samuel, starkly highlighted matters already under review in the developing policy on governance. These were matters of practice, organisation, risk, leadership and partnership (Lewis 2003).

Further influential developments have been the support under successive governments of consumer rights, the growing organisation and participation of service users and carers, and government commitment to place users and carers at the heart of policy and practice in health and social care. This trend has been coupled with a growing interest in the internationally developing ‘quality movement’, and especially in those versions which focus on the needs of the ‘consumer’ such as the ‘EFQM Excellence model”, one of the approaches favoured by government (Jackson 1999; McIver 2002). The introduction of quality systems and standards backed by internal and external regulation and inspection promised quality improvement and the correction of unacceptable variations in performance among services and between locales.

Other events within and outside the public sector have also been highly influential. Recurrent criticism of the ‘democratic deficit’ in the appointment and conduct of public bodies has been periodically intensified by allegations of political bias and ‘sleaze’ (Cornforth 2003). Meanwhile, a series of corporate failures in the private commercial sector led to growing concern to tighten external financial controls and reporting and also to the development of mechanisms for internal controls to minimise financial risk. These requirements were introduced into the HPSS in Northern Ireland in 1997 and extended from financial matters to other organisational business in 2001 (DHSSPS 2005b). Since 2003, all bodies sponsored by the Department of Health, Social Services and Personal Safety have to provide formal assurances that they have effective systems of internal control in compliance with core controls assurance standards on governance, finance and risk.

The developments described have heightened the sense of complexity of modern HPSS organisations and strengthened the view that they must be understood and managed not as individual parts but as ‘whole systems’ (Audit Commission 2002). Related to this, the UK government’s modernisation policy for the public sector has promoted partnership between services, agencies, professions and service users as essential to service effectiveness and efficiency (Whittington 2003).

Each of the influences outlined above will surface at different points in this report. Risk is a recurrent, and sometimes controversial theme: recurrent, because a key motive in developing controls systems is to calculate and minimise risk to HPSS objectives; controversial, because it has become associated with alleged defensiveness and the control of liability and reputational damage, or ‘secondary’ risk. These responses are said to be in potential conflict with quality objectives which must, unavoidably, manage and live with uncertainties (Power 2004).

There is undoubtedly a potential tension since concern with secondary (reputational) risk seems inescapable for organisations that operate in the public domain and under media scrutiny. However, the purpose of controls is avowedly to manage and control risk across the organisation's activities, but not to eliminate it. Furthermore, there is some reassurance in the matter of possible effects on services of risk controls: a key objective that is to be protected from risk, according to official guidance, is the statutory duty of *quality* itself (DHSSPS 2005).

The statutory duty of quality is accorded real status in Northern Ireland policy, being placed on a par with the high-ranking duty of financial stewardship. The duty of quality came as part of a raft of quality-related measures introduced in Northern Ireland in 2003. The measures detailed in a circular to Boards, Trusts, Councils and Groups required the appointment of a senior professional at board level to lead on clinical and social care governance and a new committee to oversee the work. Baseline information on current governance arrangements was sought along with development plans and formal reporting mechanisms (DHSSPS 2003). A team to support clinical and social care governance was also announced.

The duty of quality on Boards and Trusts began in April 2003 and states:

"Each Health and Social Services Board and each HSS trust shall put and keep in place arrangements for the purpose of monitoring and improving the quality of
(a) the health and personal social services which it provides to individuals; and
(b) the environment in which it provides them."
(Sec. 34 (1) 2003)

Plans were also put in hand for two significant lines of work as part of a framework to raise service quality: first, the development of care standards for service areas to be regulated by the new Health and Personal Social Services Regulation and Improvement Authority, later retitled the Regulation, Quality and Improvement Agency (RQIA); and second, the set of quality standards mentioned at the start of this Section (DHPSSPS 2005a). These standards are designed as a central element of clinical and social care governance in HPSS in Northern Ireland. They are for use by HPSS organisations, service users and carers, the wider public and by the RQIA to assess the quality of care provided.

References: Section 1

Audit Commission (2002) *Integrated Services for Older People: Building a Whole System Approach in England* London: Audit Commission.

Cornforth, Chris (2003) *The Governance of Public and Non-Profit Organisations*, London: Routledge.

DHSSPS (2003), *Governance in the HPSS: Clinical and Social Care Governance - Follow up to circular HSS (PPM) 10/2002*. http://66.102.9.104/search?q=cache:btmD2tn9fTAJ:www.dhsspsni.gov.uk/hss/governance/documents/circular_hss_(ppm)_10_2002.doc+HSS+(PPM)+10/2002&hl=en accessed 05/08/05.

DHSSPS (2005a) *Best Practice, Best Care: The Quality Standards for Health and Social Care* Consultation, April. http://www.dhsspsni.gov.uk/hss/governance/quality_standards.asp accessed 25/7/2005.

DHSSPS (2005b) *Controls Assurance Standard HPSS – Governance* http://www.dhsspsni.gov.uk/hss/governance/documents/governance_05.pdf accessed 03/08/05.

Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order (2003) Statutory Instrument No 431 (N.I. 9). http://www.opsi.gov.uk/si/si2003/20030431.htm accessed 05/08/05

Jackson, S. (1999) "Exploring the possible reasons why the UK Government commended the EFQM excellence model as the framework for delivering governance in the new NHS", *International Journal of Health Care Quality Assurance* 12, 6, 244-253.

Lewis, R. J., Cole, D., & Williamson, A. (2003) *Review of Health and Social Services in the Case of David and Samuel Briggs*. http://www.dhsspsni.gov.uk/publications/2003/lewis.pdf accessed 13/12/05.

McIver, S. (2002) *Quality of Service. Briefing Paper for the Review of Public Administration in Northern Ireland*. RPANI . http://www.rpani.gov.uk/quality/ accessed 03/08/05.

Power, M. (2004) *The Risk Management of Everything* Demos www.demos.co.uk/ riskmanagementofeverything_pdf_media_public.aspx accessed 07/01/06.

Ritchie, J. H., Dick, D., & Lingham, R. (1994) *The Report into the Care and Treatment of Christopher Clunis*, London: HMSO.

RPA (Review of Public Administration) Team (2005) *Review of Public Administration in Northern Ireland: Further Consultation* http://www.rpani.gov.uk/consultdocu.pdf, accessed 02/08/05.

Secretaries of State for Health and the Home Department (2003) *The Victoria Climbié Inquiry: Report of an Inquiry by Lord Laming* HMSO, Norwich.

Secretary of State for Health (2001) *Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995,* (The Kennedy Report) Cm 5207 London: The Stationery Office.

Smith, D. J. (2004) *The Shipman Inquiry Fifth Report - Safeguarding Patients: Lessons from the Past - Proposals for the Future* Cm 6394 Norwich: HMSO.

Whittington, Colin (2003) "Collaboration and Partnership in Context," in *Collaboration in Social Work Practice*, J. Weinstein, C. Whittington, & T. Leiba, (eds), London: Jessica Kingsley, pp. 13-38.

2. The goal and duty of quality

The Quality Standards are encompassed in five quality themes, which were identified in consultation with key stakeholders and in a review of local, national and international standards. The themes are (DHSSPS 2005a):

1. Safe and effective care
2. Timely delivery of quality services
3. Promoting, protecting and improving health and social wellbeing
4. Open and effective communication
5. Leadership and accountability of organisations

Possible revisions to the wording and order of the list are as follows (DHSSPS 2005b):

1. Corporate leadership and accountability of organisations
2. Safe and effective care
3. Accessible, flexible and responsive services
4. Promoting, protecting and improving health and social wellbeing
5. Effective communication and information

In both versions, the standards are detailed and recognise the need for periodic review in the rapidly changing environment of HPSS. Running through the standards is the principle of involvement of service users and carers. The standards are described as 'essential' in the sense that they represent "the minimum to ensure safe and effective practice" (DHSSPS 2005a, p2; 2005b, p.5).

In defining 'essential' in these terms, the standards point to the particular significance of the quality theme of 'safe and effective care'. Indeed, analysis of the standards for this report suggests that while all are deemed essential, the particular theme of 'safe and effective care' stands out as core. A second theme, 'accessible, flexible and responsive services' augments that core theme, elaborating on the style or modality of safe and effective care. Other themes in the standards may be thought of as 'enabling' the achievement of safe and effective care.

The discussion will come back to governance but for now it is important to explore further the key goal that Trusts must pursue, the goal of 'quality', and to relate it to social care.

Quality may be defined as the characteristics by which a service is judged. *The Quality Standards* and, in particular the theme of safe and effective care and the principle of involvement of service users and carers, provide a basis for saying what those characteristics are:

Fig. 1

3 key characteristics of a quality service

The service is:

- effective
- uses practices that are safe
- involves service users and carers

The contents of Fig. 1 are clarified in fig. 2.

Fig. 2

Clarifying the characteristics of a quality service

Q. ‘effectiveness’ of what?
A. service *outcomes* and service *experience*

Q. ‘practices that are safe’ in relation to whom?
A. *service users and carers*, *staff* and *the public*

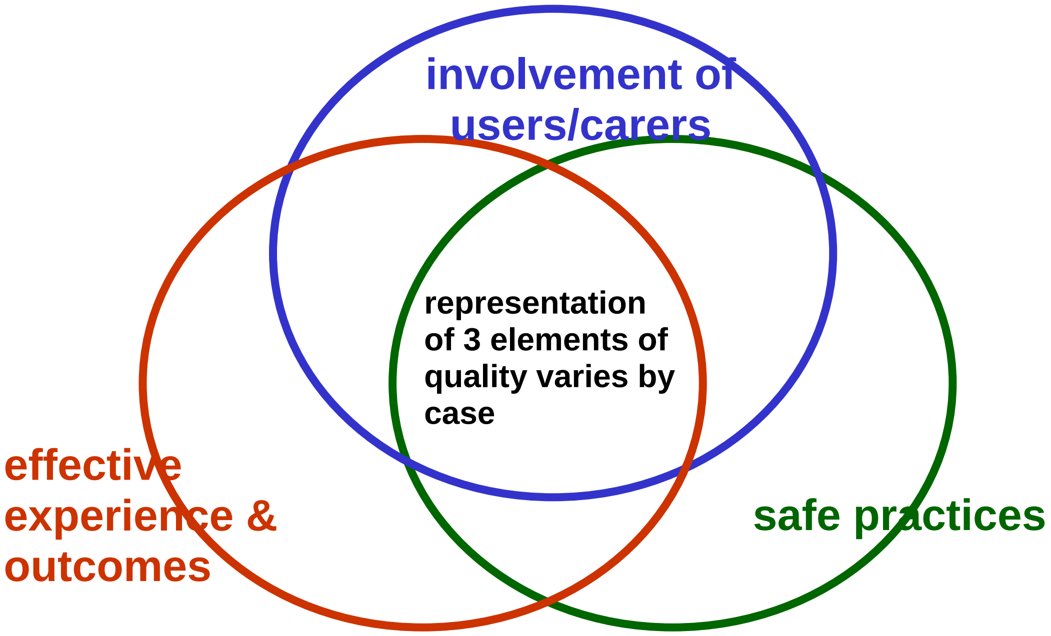
Q. involvement in what?
A. in the social care service being received

Principles of involvement include involving service users and carers in service planning and development and the report will return to this but, for the present, the focus is on involvement in the service being received. The three characteristics, *effectiveness, safety* and *involvement*, are not separate entities but interact. Safe practices emphasise risk management for service users and carers and for staff but this is qualified by the goals of effective outcomes and experience and by the involvement of service users and carers.

This qualified approach to risk and safety is supported by evidence that service users do not seek over-protection and wish to judge and take risks for themselves (DH 2005 ref 240). The qualified approach is also endorsed in *The Quality Standards* (DHSSPS 2005a para 2.2 & pp.15-16). Safe care practices are those that properly assess risk and make informed judgements about them in consultation with relevant parties. The safety of the wider public is a factor in this process.

A list does not convey the dynamic nature of the three quality characteristics. Figure 3 suggests a more dynamic picture. Effectiveness, safe practices and involvement are elements of quality in any given case. That is, quality is the product of these elements, which will vary in any given instance, blending different aspects of effective outcome and experience, safe practice and service user and carer involvement. For example, in certain cases the priority of safe care practice might gain precedence over a service user's or carer's involvement in a decision. The subjective care experience might accordingly be affected but the effectiveness of the outcome enhanced.

Fig. 3 Combined and interacting characteristics of a quality service



The characteristics for judging quality are summarised in Figure 4 below.

Fig. 4

Characteristics for judging quality

1. effectiveness of social care
    - outcomes
    - the experience (includes especially 3)
2. safe care practices in relation to
    - service users and carers
    - staff
    - the public
3. involvement of service users in their own care service

Question remain about how these characteristics are defined. This will vary between individual cases and situations. The best course here is to say who does the defining and to recognise that:

- different definers will hold sway in different cases
- definitions and criteria vary over time
- definitions sometimes compete or conflict; for instance, services users are not always willing partners in some statutory work
- social care practitioners and managers regularly have to weigh and negotiate competing definitions, criteria, interests and demands.

With these qualifications, the question can be asked: from whose point of view are the quality judgements made? The answer is summarised in Figure 5.

Fig. 5

From whose point of view are the quality judgements made:

- service users and carers
- social care staff
- the HPSS agency/organisation
- social care values and codes

The perceived views of other stakeholders act as additional reference points in the judgements being made. They include the regulators of HPSS and the public, although determining the nature of public opinion and whose voice should be heard – the media, politicians, pressure groups or individuals – can be problematic.

The foregoing analysis, prompted by the *Quality Standards,* gives the basis for a working interpretation of the statutory duty of quality (Fig. 6).

Fig. 6 Working interpretation of statutory duty of quality

Working interpretation:
The statutory duty of quality means striving to ensure that:

1. *care outcomes* are *effective* in meeting expectations of
    - service users and carers
    - agency objectives and social care values/codes
2. *care experience* (process) is *effective* in meeting expectations of
    - service users and carers
    - agency standards and social care values/codes
3. *care practices* are *safe* for
    - service users and carers
    - staff
    - the public
4. *service users* and *carers* are *involved*

The duty of quality also means having in place a series of structures, practices and procedures, that is, 'enabling' mechanism, that serve the goals of effective, safe, user-involved practices. The combination of the key characteristics of a quality service with these enabling mechanisms will provide the basis for a model for social care governance to be described later. The discussion re-connects here with *governance* which is given a central role in the *Quality Standards* in responding to the duty of quality (DHSSPS 2005a, p.2). The role given to governance is two-fold:

- to assist in fulfilling the duty of quality

- to demonstrate that the duty is being met (accountability)

References: Section 2

DHSSPS (2005a) *Best Practice, Best Care: The Quality Standards for Health and Social Care* Consultation, April. http://www.dhsspsni.gov.uk/hss/governance/quality_standards.asp accessed 25/7/2005.

DHSSPS (2005b) *The Quality Standards for Health and Social Care Supporting Good Governance and Best Practice in the HPSS Nov 2005*.

Department of Health (2005) *Responses to the consultation on adult social care in England Analysis of feedback from the Green Paper: Independence, Wellbeing and Choice*, http://www.careknowledge.com/ck/application_store/content_store/ASGResponse041216242005Oct21103645.pdf accessed 28/10/05.

3. The nature and dimensions of governance

Terms and meanings

Governance is a term with mystifying powers. Coupled with a culturally powerful idea like ‘good’, as in ‘good governance’, the power grows while questions about meaning may be overlooked. The commission for this report puts those questions firmly on the agenda.

Trawls of the literature, the internet and public policy for the report supported by a range of discussions (see p.15 check), found widening but sometimes loosely-defined or abstract, usage. The research also found reference to many *types or levels* of governance:

- political governance
- collaborative or partnership governance
- integrated governance
- corporate governance
- financial governance
- information or IT governance
- research governance
- clinical governance
- social care governance
- practice governance

It is not surprising that governance has been described as the new generic name for ‘public management’ or ‘public administration’ (Peters and Pierre 1998). The *combined scope of the different types* is great and covers:

- the international, national and local work of governments
- the business of boards
- stewardship
- public protection
- board-management relations
- partnership between organisations
- stakeholder relations
- the policy-making process
- strategic management
- operational management
- service delivery.

Within the descriptions of the different types, governance represents, variously:

- a symbol of corporate integrity, probity, accountability and leadership
- ways of structuring organisations and their key roles and relationships
- sets of values and aspirations

- methods for achieving service standards
- an organisational or civic role
- a set of political, organisational or professional objectives
- a system for protecting, monitoring, accounting for and supporting those objectives.

This broad and sometimes confusing range provides one of the arguments for the decision in this report to focus on a central idea, *quality*, and its characteristics in the direct provision of social care services. The aim is to focus on primary objectives of social care and thereby both reduce the diffuseness of governance and manage its complexity. The report will return to this theme but first, greater clarification of the term governance is needed.

Corporate governance and care practice: finding connections

A search for origins and commonality amid the many levels and meanings of governance finds the term prevalent in the business of governments, corporations and governing bodies and serving a common concern with the control, direction and accountability.

This inheritance is illustrated in the formality of mandatory compliance with 'core standards' of governance which is required of HPSS organisation.

> "The Governance Standard is a high-level 'overarching' core controls assurance standard and is supported by two additional core standards covering Financial Management and Risk Management. Compliance with the core standards is mandatory as they are central to the whole risk management and controls assurance agenda and form the foundations of best governance practice." (DHSSPS 2005a)

While both mandatory requirements and questions of risk are familiar to practitioners, the formality and high-corporate imagery of such descriptions can make governance seem remote from the front-line worlds of social care and clinical practice and prompts some practitioners to ask: 'where is the connection?'

The answer rests in the joining of the two terms and of the spheres they represent, that is of 'social care' or 'clinical care' on the one hand, and 'governance' on the other. What is being constructed in the idea of *social care governance* is a way of connecting the *professional* and the *organisational* and of binding them in a common enterprise.

While *corporate* governance seems remote from practice of the front-line service, a brief exploration helps to show the context in which the ideas of governance in social care and clinical practice are constructed. Drawing on an HM Treasury definition, the DHSSPS website outlines corporate governance as:

> “the system by which an organisation directs and controls its functions and relates to its stakeholders. In other words, the way in which organisations:
>
> - manage their business
> - determine strategy & objectives
> - go about achieving these objectives”

Citing a ministerial speech the website says that “governance arrangements must span all aspects of our business, whether: financial; organisational; or *the planning and delivery of care*” (DHSSPS 2005b, italics added).

The Audit Commission enlarges the picture, defining corporate governance as:

> “The framework of accountability to users, stakeholders and the wider community, within which organisations take decisions, and lead and control their functions, to achieve their objectives” (Audit Commission, 2003)

The Commission adds that in the NHS:

> “The corporate governance stream considers matters in relation to controls assurance, such as internal and external audit, risk management, financial management and complaints. “ (Audit Commission 2003)

The descriptions above are the product of a body of ideas that influenced the new concept of *clinical* governance, which was introduced in 1997 and is discussed further below.

Clinical and Social Care Governance

The White Paper, *The New NHS: modern. dependable* set in train the development of clinical governance (Secretary of State for Health, 1997). Definitions of the term abound (Jones and Worral 2005, p.4) but the following, originated by Donaldson and Scully in 1998, is widely-found:

> Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish” (DH 2005a).

Building on this definition, *Best Practice Best Care* extended the concept to social care in 2001, describing clinical and social care governance as:

> "a framework within which Health and Personal Safety Service organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment. Clinical and social care governance is about organisations taking

> corporate responsibility for performance and providing the highest possible standard of clinical and social care" (DHSSPS 2003)

These two descriptions of governance demonstrates the organisational and professional dimensions mentioned earlier. The *organisation* (the management and board) is present in the expectation of:

- corporate responsibility for improving quality and safeguarding standards (seeing that they are is done),
- accountability (showing that they are done and being answerable for it)
- creating the environment in which they may flourish.

The *professions* are present in

- delivering the care and treatment
- being accountable for doing so to a required standard.

The idea of 'continuous' improvement in the definition echoes the influence of the quality movement, total quality management (TQM) and 'continuous quality improvement' (CQI). The underlying assumption is that organisations and their environments are complex and continually changing and that continuous reassessment of structures, processes, services and practices are needed to sustain high standards of delivery.

Nevertheless, the idea of CQI raises a debate over the practical limits to improvement and its resource implications. Practical limits was a significant issue for the front-line managers and practitioners who participated in the focus groups conducted to inform this project. These staff members were, on the one hand, unanimously committed to the goal of a quality service and arrangements necessary to achieve this goal and, on the other, equally unanimously concerned at the effect of restricted resources in compromising quality (Focus groups November 2005).

The introduction of *clinical governance* in the NHS has brought not just broad definitions but descriptions of the main elements. Again, these descriptions abound and vary in their content but a well-known example conceives a structure of patient-professional partnership supported by seven pillars of clinical governance consisting of effectiveness in clinical work, clinical risk management, the patient experience, communication, use of resources, strategy and learning (CGST 2005; DHSSPS 2004). The precise application of this model in practice varies because of local interpretation and priorities and the inherent complexity and change in clinical government and its environment (Sweeney and Cassidy 2002).

Most interpretations of clinical governance include patient involvement, clinical audit, clinical risk management, clinical effectiveness, training and continuous professional development, clinical information management and staffing. The inevitable and recurrent use of the term 'clinical' may distance social care staff from this set of activities and hamper transfer. However, it is possible to express them in a language that is adapted to social care as well as to clinical practice, in order to suggest some common activities for clinical and social care governance (which in some forums are referred to collectively as practice governance). The activities are shown in Fig. 7 below.

Fig. 7 Some common activities of clinical and social care governance

Element	**Implications for the organisation and its staff**
service user, carer and public involvement	involve users and carers in individual services, service planning and review, and consult the public
complaints and compliments management	respond to and learn from complaints and compliments
risk management	recognise and assess risk; decide on risk reduction; and report and act on adverse incidents
audit	measure performance against defined standards and targets
evidence-based practice	demonstrate application of practice evidence from formal sources, peer exchange and reflective practice
information management	develop and use systems and practices for recording, reporting, accessing, sharing and protecting information
staff training and continuous professional development	resource and participate in learning and development including good practice exchange
staffing and staff performance management	resource and recruit staff of the required standard, monitoring and supporting performance and acting to improve it where needed

These activities are not inherently neutral, nor is their nature self-evident. The activities embody values and their translation into operational methods will be affected by the professional assumptions and priorities of their translator. More will be said of this below. Before that, however, it is worth noting from a social care perspective, the common ground likely to be found with health care staff in the following extract from a recent key NHS planning document (Department of Health 2005b, p.21).

“The scope of the new quality programme which is emerging in the NHS is bold and broad-based. Underpinning this has been the concept of clinical governance - a unifying concept for quality which provides organisations with a systematic means for ensuring that they comply with their statutory duty [of quality]. It aims to effect a change of culture in NHS organisations to one where:

> 'openness and participation are encouraged, where education and research are properly valued, where people learn from failures and blame is the exception rather than the rule, and where good practice and new approaches are freely shared and willingly received.' (Sir Liam Donaldson, Chief Medical Officer)"

The sentiments chime closely with an earlier statement on cultural change and clinical and social care governance in Northern Ireland:

> "A culture that encourages open discussion and reflection on practice allows staff to learn from their experiences. This includes both celebrating what is done well and learning from what is done less well. (DHSSPS 2003 para 14)."

What are the differences between clinical and social care governance and what does social care bring to governance?

It is not possible to answer questions about the difference of social care and clinical governance directly for the following reason. *There is an established and developing body of knowledge and practice in clinical governance, but the research for this report found that there is no direct equivalent in social care.* There is published material on clinical *and* social care governance, primarily resulting from Northern Ireland initiatives, and locally-developed materials supporting 'practice governance' in integrated health and social care settings in agencies elsewhere (DHSSPS 2004; Wells, 2004 Hertfordshire). In neither case, however, does this amount to a body of material on social care governance alone.

Instead, it is necessary to think about the domains of clinical practice and social care practice, respectively, and some of the ways in which they appear to differ or in which social care may be distinctive. Five inter-related areas will be considered. It is necessary to speak in broad terms and to recognise variation from the picture given. The suggested contributions of social care will be summarised at the conclusion of the discussion. The five areas are: knowledge culture; model of profession; quality infrastructures; inter-agency and interprofessional dimensions; and professional values.

(i) The ***knowledge culture*** of the health professions, led particularly by medicine, is influenced especially by an ostensibly value-free scientific positivism, theories of cause and effect and the methods of randomised controlled trials (Sweeney 2002). Research and evidence in social work and social care are arguably more eclectic and derive knowledge from multiple sources (Pawson *et al* 2003). These sources include a significant strand of qualitative, interpretive theory and method.

Positivistic and interpretive perspectives embody, respectively, different assumptions about how people and their circumstances are to be understood and the parts that the professional and the service user play in constructing that understanding (Whittington, forthcoming). To simplify, the positions contrast the idea that health and social care problems can be understood either as objective facts with underlying causes and solutions, or as socially-constructed by all of those involved and especially by those with the social power to gain acceptance of their view of a situation (Hall *et al* 2003). Both paradigms sub-divide into a range of theoretical perspectives and many of them are represented in social work, which has its own adherents to positivistic approaches (Whittington and Holland 1985; Whittington 2005). The respective perspectives are potentially important for governance since they affect the confidence that is placed in methods that seek cause and effect evidence of interventions or expect reliable prediction of risk (Trinder and Reynolds 2000).

The different assumptions are also important because they underlie aspects of the familiar debate between medical and social models of illness, disability and care. The social model mixes social causation and construction with the values of self-determination, empowerment and user involvement discussed in Section 4. For example, the social model seeks to understand and alter the disabling effects of the social and physical environment while the medical model is said to concentrate on the individual, his or her condition and its treatment and management (Jones 2005). Both accounts are simplifications and need not be mutually exclusive. They converge, for instance, in branches of public health, some schools of mental health practice and in work on complexity in healthcare (Sweeney 2002). Arguably, an integrated service and its governance needs both perspectives. However, in some settings, the social model can be marginalised whereas, as one contributor to this project put it:

> “effective practice governance means [applying] health *and* social care perspectives”

There is no ultimate arbiter of different perspectives but, in both models, medical and social, the knowledge applied by professionals needs to meet a standard (Pawson et al 2003). The report will return to these issues under discussion of evidence-based practice.

(ii) The traditional ***model of profession*** is characterised by a hierarchy in the relationship between the expert service-giver and the lay service-user. This hierarchy is symbolised and reinforced by regulation of professionals by professionals, by the profession’s control of its own training and by independence in practice, which varies in degree between professional groups.

Health professions more or less conform to this model, but social work and social care generally do not. For example, the institution of care councils in the UK gave authority to the voice of the non-professional stakeholder, including service users and carers, in the training, occupational requirements and regulation of professional conduct (Whittington and Whittington, forthcoming). Furthermore, social work and social care have typically gained their authority and functions from organisational employment and have built values of organisational accountability into their ethical codes and their models of practice supervision, matters which are said to cause heated debate among health professions (Roy 2005) .

This outline suggests two things. First, that social work and social care do not replicate the traditional model of profession and secondly that, as one informant put it :

> "They [social workers] are adapted, through their professional cultures and organisational experience, to line management, supervision and organisational accountability".

The informant was not suggesting that being thus adapted makes social care professionals organisationally docile. Social care professionals were seen, instead, to understand the kinds of organisational imperative that governance brings and to have a capacity to contribute to the balancing of organisational and professional objectives. In addition, the recognition by institutions such as the NISCC of stakeholder input and, especially, of service user input to the highest levels of professional governance, creates a favourable climate among social care staff for similar user roles in local governance and for the role of practitioner as enabling *partner* with service users and carers.

(iii) Clinical governance and social care have different ***quality infrastructures*** supporting their activity. Clinical governance arises directly from reforms in the NHS and relies in part on an evidence-based approach supported by a developed and funded scientific knowledge and research infrastructure. There is no equivalent infrastructure in UK social care whose evidence base is only now being developed systematically by organisations like SCIE. Quality infrastructures in social care have tended to develop around compliance criteria and performance indicators backed by external and internal quality inspections. These methods have been augmented in some quarters with performance management linked to one of the quality approaches recommended in the White Paper, *Modernising Government* (IDeA 2006, p.3).

The effective establishment of social care governance will require a support infrastructure to develop the evidence base. This development will bring different contributions since it will require different kinds of evidence production from those conventionally associated with health research:

> "The democratisation of welfare, and the move towards citizen participation in social care, requires a different kind of evidence production than one where the professional expertise and the priorities of providers take precedence. As citizens, people who use and provide services need to be directly involved in determining what kind of knowledge should be

> sought, what research processes should be used and what outcomes matter. The traditions of participatory and empowerment research that permeate the best social work research place it in a strong position to respond to this agenda.” (Marsh and Fisher 2005)

(iv) There has been growing recognition that effective everyday practice in social work and social care is indispensably bound up in relationships with other professions and agencies. This ***inter-agency and interprofessional dimension*** was taken for granted for many years, a self-evident fact of practice life in which to get things done, with and for service users, meant working with others. This dimension is now firmly recognised, for example, in the requirements and occupational standards for the social work degree and is included in post-qualifying standards and care NVQs (TOPSS 2004; Whittington 2003).

This is not to suggest that social work is more advanced than health professions and clinical practice in developing interprofessional perspectives but two things do seem to stand out. First, social work and social care organisations give as much prominence to the *inter-agency* dimension of collaboration and partnership as to the interprofessional component (Whittington and Whittington, forthcoming). Secondly, models of *clinical* governance tend to focus on the professional, team and organisational aspects of quality and accountability (Sang 2006). Interprofessional and inter-agency aspects, and partnership, if included, tend not to be central.

(v) Professions do not own their ***professional values*** yet they do sometimes claim a special relationship as ‘early adopters’ of particular values (Whittington, forthcoming). Social work and social care have taken this stance in promoting equal opportunities, anti-discrimination and diversity and have sought to lead in building values of involvement of service users and carers into professional method (Higham 2005). These values are embedded in explicit expectations in social care codes and social work training (NISCC 2002).

The ethical codes they generate are likely to be reflected in social care priorities for governance. There are points of difference here with professions who give a lower priority to ‘equalities’ or who take a more hierarchical view of the relationship with service users. Social care has a strong resource base of materials to contribute to service user and carer involvement (see http://www.scie-socialcareonline.org.uk/). Social care codes, ethics and training requirements also expect practitioner cooperation and partnership with other professions and agencies and recognise the need for organisational accountability and sound supervision, while the social care employers’ code strongly underpins these dimensions (NISCC 2002; BASW 2003).

The discussion has considered five areas: knowledge culture; model of profession; quality infrastructures; inter-agency and interprofessional dimensions and professional values. Aspects that may be distinctive to social care have been described and it is now possible to summarise the associated contributions that social care can bring to governance.

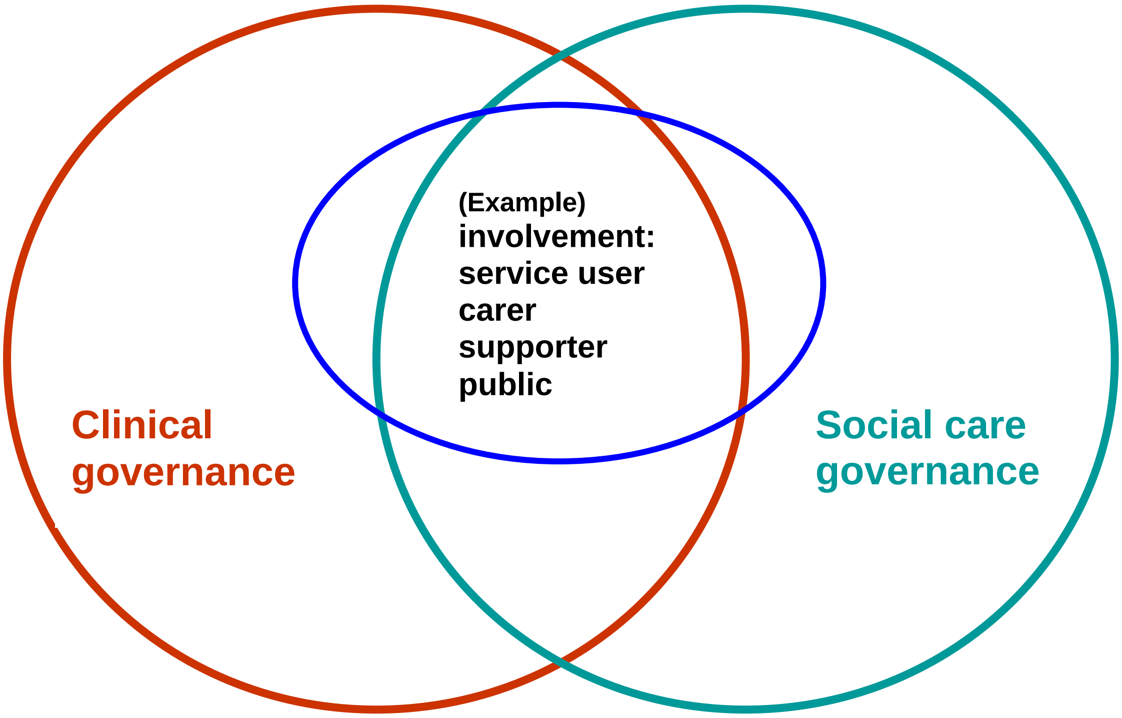
Summary of the contributions that social care can bring to governance

- a social model of social, personal and health problems
- a recognition that official conceptions of service users and user needs are socially constructed and, therefore, in principle, amenable to critical review and revision
- a non-traditional model of profession conducive to involvement of service users and carers and to equal partnership with other occupations and professions
- collaboration and partnership with other agencies and professions as fundamental to practice
- experience of participatory and empowerment research
- established codes of ethics and practice that foster
    - equal opportunities, anti-discrimination and respect for diversity
    - partnership with and involvement of service users and carers
    - partnership with other professions and agencies
- recognition of the role of effective line-management and organisational accountability
- developed methods for supervision and understanding of its contribution to staff support and quality services

Domains of clinical and social care governance: Common and distinctive aspects

The discussion, respectively, of clinical governance and social care governance thus far characterises twin domains that have both common aspects and distinctive characteristics or emphases. This view is illustrated in Figure 8, which takes service user involvement as an example of a common goal, represented within the two overlapping large ellipses. Portions of the (blue) user involvement ellipse remain, however, outside the common area. That is, they remain in the two respective domains, indicating that some interpretations of ‘involvement’ (and by implication, of other common aspects) may be distinctive to one domain or the other.

Fig. 8 Common and distinctive domains of clinical and social care governance



Origins, imagery and the generation of commitment

The line that runs from the originating ideas of corporate governance through clinical governance to social care governance makes it, ostensibly, a top-down phenomenon promoted by senior policy-makers and managers. This lineage does not suggest a practice that has been demanded or directly initiated by front-line social care professionals and managers, yet they are primarily the people who must make social care governance work and it is their professional goals that governance should facilitate. Nor does the lineage suggest that the origins of social care governance lie in the direct demands of service users and carers whose interests it should serve. On the contrary, the origins and imagery of governance makes it sound managerial not professional or lay; while *clinical* governance sounds medical and managerial.

There is a challenge here in securing the commitment and trust of all the parties. This is not a burden of responsibility that falls to managers and policy-makers alone. For their part, social care staff have a professional and organisational responsibility to engage with governance but their *level* of engagement will arguably be enhanced by the association of governance with a core set of ideas with which they can identify fully as professionals. This argument provides a further rationale for offering ‘quality service’ as the core idea for this report with its elements of:

effective care and safe and involving care practices

There are other aspects of imagery that needs consideration, however, related to ‘accountability’ and management of ‘risk’. The two are components of most governance systems and they vie with the notion of ‘quality’ for the place of central idea. Yet risk can be effectively accommodated in the goals of safety and effectiveness (which are components of quality as defined). As for ‘accountability’, the reported experience of clinical governance is that if governance is interpreted primarily as a ‘framework of accountability’, then it shifts attention more to the “implications for trust managers” than for practitioners and teams (Worral 2005, p.90). However, “if governance is interpreted as a generic term for *a range of quality activities* [italics added], then…team members will be more involved” (Worral 2005, p.90). In this formulation, accountability remains crucial to the social care governance equation, but as a mechanism to facilitate a quality service, not as its dominating purpose.

It is suggested here that the goal of effective, safe and involving care offers a unifying objective around which a compact on governance may be forged not only with staff but with service users and carers too. Two further factors will engender and sustain commitment: direct experience and wider evidence that governance is helping to achieve the quality goals. The knowledge that governance structures are in place will not be enough. Evidence of their effects will be needed too.

The elements of social care governance: towards a model

It is now possible to set out in advance of later discussion, some essential elements and constituent activities of a model of social care governance. Four elements have been distilled from the project sources described in the Introduction to this report. Some aspects have been indicated already and others will be elaborated in later sections (Fig. 13 and Parts 2 and 3).

Four essential elements of a model of social care governance:

- **engaging with key stakeholders**
- **assuring quality and accountability**
- **professional and organisational learning**
- **leading, managing and participating**

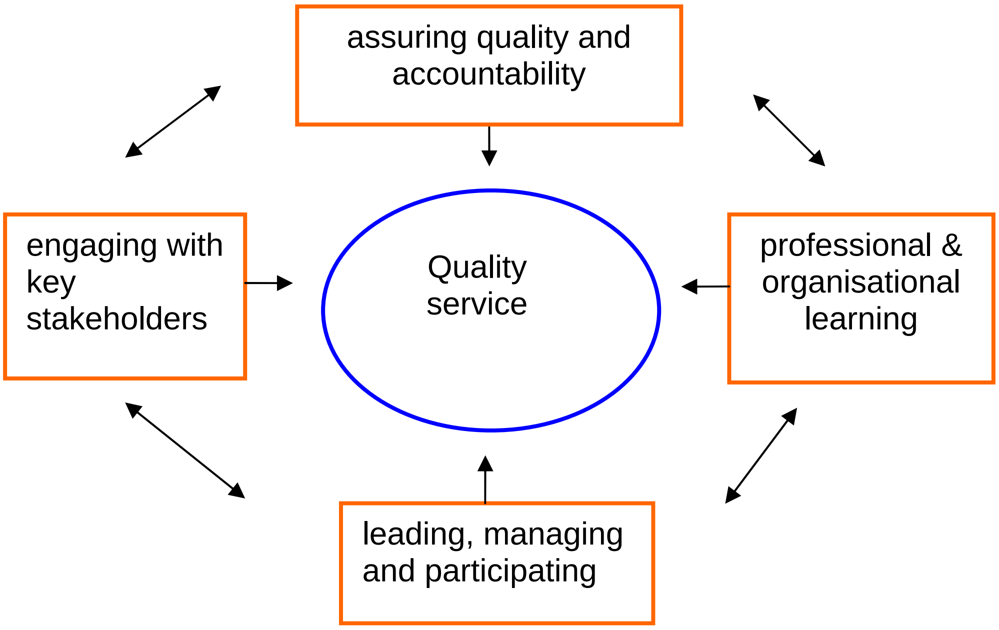
As will be elaborated later, the first element groups together activities concerned with ***engaging****,* and recognises key stakeholders and their contributions; these stakeholders - service users and carers, other professions and agencies and the Trust’s own staff, must be engaged through partnership and the exchange of information to achieve a quality service. The second element is ***assuring quality and accountability***, and recognises particular methods. The methods are given later in Figure 13 and indicate the main areas but the list is not fixed and is open to addition or adaptation.

The third element is ***professional and organisational learning*** and underlines the indispensability of learning from the experience of engagement and from the multiple sources available including quality assurance methods. In short, effective modern organisations must be learning organisations (SCIE 2005; Gould and Baldwin 2004).

As illustrated later in Figure 13, the learning from the third element should flow into the fourth element, which refers to ***leading, managing and participating***. The role of manager features less strongly in accounts of *clinical* governance than the role of the clinician, while *corporate* governance, with its concern for system principles and probity, sometimes stands at a different level from the organising practices of management. Management of social care governance systems, however, is indispensable while leadership is essential too, falling both to managers and to others on the basis of their expertise and creativity (DHSSPS 2005c). Finally, since effective social care governance depends on the contribution of the widest possible expertise, participation is essential and gives both responsibility and opportunity to all members of staff in the pursuit of a quality service.

It is important to say that the four elements or groups of activities are not discrete or watertight compartments. They are parts of a system within the model and interact and overlap. They are represented below (Figure 9) and their relationship is developed further in Figure 24 at the end of Part Three of this report.

Fig. 9 Interacting elements of social care governance



Are there areas where clinical governance and social care governance need to differ?

This question was posed in the commission and its implications are two-fold:

1. that social care brings important features to governance and the goals of a quality service

2. that some features may be submerged if a culture of clinical practice were to dominate.

Arguments in favour of the first point have already been advanced above. The key word in the second point is ‘dominates’. One implication of the preceding discussion is that no single set of interests should dominate a governance system and certainly that the social care contribution should not be submerged. This is not an argument, however, for solution by separation. For one thing, clinical governance is a rich source of experience and learning materials. For another, the structure of services in Northern Ireland, and the goal across the UK, is towards greater integration and joint working as dictated by the needs and expectations of service users and carers whose requirements frequently extend beyond the artificial boundaries of given professions or service categories. In this context, governance confronts the same imperatives as faced by the HPSS more broadly, to work in partnership and to negotiate the contributions of the major stakeholders, including both clinical and social care staff.

With this in mind, it is suggested that the four elements of social care governance outlined above may be generic to social care and to clinical governance. Although this report will continue to focus on social care governance as commissioned, it is worth noting that some joint services have adopted the term ‘practice governance’ to embrace the two dimensions.

Why does development of a model of social care governance matter?

A model of social care governance matters because it represents:

- systematic and serious efforts to avoid service failures, reduce unacceptable variations in standards and achieve a high quality service

- a commitment to place the needs of, and responsiveness to, service users and carers at the heart of policy and practice

- an endeavour to connect the different parts of modern health and social care systems and to value and use partnership to make them work effectively

- the contribution of distinctive and valuable social work and social care expertise to the enterprise of a responsive, user-centred and carer-centred, effective and safe health and social care services.

References: Section 3

Audit Commission (2003) *Corporate Governance: Improvement and trust in local public services* http://www.audit-commission.gov.uk/Products/NATIONAL-REPORT/7374209E-8060-4218-B4B2-2CCF2FD490C5/CorporateGovernance.pdf accessed 08/08/05.

BASW (British Association of Social Workers) (2003) *Code of Ethics for Social Work* http://www.basw.co.uk/articles.php?articleId=2 accessed 08/08/05.

CGST (Clinical and Social Care Governance Support Team) (2006) *Clinical Governance,* http://www.cgsupport.nhs.uk/downloads/Core_CG.pdf accessed 06/01/2006.

DH (Department of Health) (2005a) *Clinical governance*. http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ClinicalGovernance/fs/en accessed 5/8/2005.

DH (2005b), *National Standards, Local Action - Health and Social Care Standards and Planning Framework 2005/06–2007/08*. http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPAmpGBrowsableDocument/fs/en?CONTENT_ID=4096173&MULTIPAGE_ID=4894544&chk=fVAQZK accessed 02/08/05.

DHSSPS (2001) *Best Practice Best Care A framework for setting standards, delivering services and improving monitoring and regulation in the HPSS,* A Consultation Paper, http://www.dhsspsni.gov.uk/publications/2001/4161contentsintro.pdf accessed 21/8/205.

DHSSPS (2003), *Governance in the HPSS: Clinical and Social Care Governance,* - Follow up to circular HSS (PPM) 10/2002 http://66.102.9.104/search?q=cache:btmD2tn9fTAJ:www.dhsspsni.gov.uk/hss/governance/documents/circular_hss_(ppm)_10_2002.doc+HSS+(PPM)+10/2002&hl=en accessed 17/10/05.

DHSSPS (2004) *Governance in the HPSS - The Whole Picture,* *http://www.dhsspsni.gov.uk/hss/governance/learning.asp* accessed 28/07/05.

DHSSPS (2005a) *Controls Assurance Standard HPSS - Governance*. http://www.dhsspsni.gov.uk/hss/governance/documents/governance_05.pdf accessed 13/12/2005.

DHSSPS (2005b) "What is 'Governance'"? http://www.dhsspsni.gov.uk/index/health_and_social_services/governance.htm accessed 24/08/05.

DHSSPS (2005c) *Best Practice, Best Care: The Quality Standards for Health and Social Care* Consultation, April. http://www.dhsspsni.gov.uk/hss/governance/quality_standards.asp accessed 25/7/2005.

Gould, N. and Baldwin, M. (eds) (2004) *Social Work, Critical Reflection and the Learning Organization*, Aldershot: Ashgate.

Hall, C., Juhila, K., Parton, N., & Poso, T. (2003) *Constructing Clienthood in Social Work and Human Services* London: Jessica Kingsley.

Higham, P. (2005) “What is important about social work and social care” *SSRG Newsletter,* July.

IDeA (Improvement and Development Agency) (2006) *Review of Performance Improvement Models and Tools*, http://www.idea-knowledge.gov.uk/idk/aio/1551334, accessed 01/02/06.

James, A. and Worrall, A. (2005), "Introduction" in *Clinical Governance in Mental Health and Learning Disability Services: A Practical Guide*, A. James, A. Worrall, & T. Kendall (eds) London: Gaskell (Royal College of Psychiatrists), pp. 3-13.

Jones, R. (2005) “The Green Paper and Social Work”, *Care and Health* 10th-16th May, pp. 18-19.

Marsh, P. & Fisher, M. (2005) *Developing the evidence base for social work and social care practice*. Using knowledge in social care: SCIE Report 10. http://www.scie.org.uk/publications/reports/report10.pdf accessed 9/01/06

NISCC (2002) *Codes of Practice for Social Care Workers and Employers of Social Care Workers* Belfast: NISCC.

Pawson, R., Boaz, A., Grayson, L., Long, A., & Barnes, C. 2003, *Types and Quality of Knowledge in Social Care,* London: SCIE.

Peters, G. & Pierre, J. (1998) “Governance Without Government? Rethinking Public Administration”, *Journal of Public Administration Research and Theory,* 8, 227-243.

Roy, D. (2005) "Monitoring and Improving Performance," in *Clinical Governance in Mental Health and Learning Disability Services: A Practical Guide*, A. James, A. Worrall, & T. Kendall (eds), London: Gaskell (Royal College of Psychiatrists), pp. 266-284.

Sang, B. 2006, "Fixing the broken triangle: improving patient and public involvement in clinical governance, locally and nationally," in *Clinical Governance in a Changing NHS*, M. Lugon & J. Secker-Walker (eds), London: Royal Society of Medicine, pp.19-33.

SCIE (2004) *Learning Organisations: a self-assessment resource pack* London: SCIE.

Secretary of State for Health (1997), *The new NHS: Modern, dependable,* Cm 3807 London: TSO.

Sweeney, K. & Cassidy, C. 2002, "Clinical Governance and Complexity," in *Complexity and Healthcare*, K. Sweeney & F. Griffiths (eds) Abingdon: Radcliffe Medical Press pp. 123-147.

TOPSS England (2004) *National Occupational Standards for Social Work*, http://www.topssengland.net/files/SW%20NOS%20doc%20pdf%20files%20edition%20Apr04.pdf accessed 27/09/05. (ref 121)

Trinder, L. & Reynolds, S. (2000) *Evidence-based Practice: A critical appraisal* Oxford: Blackwell.

Wells, J. (2004) "Practice Governance Groups: headings for workplan, terms of reference and standing agenda" Hertfordshire Partnership Trust .

Whittington, Colin (2003) "Social Care Workforce Development for Multi-Disciplinary and Multi-Agency Services" *CareKnowledge Briefing* No 11, http://www.careknowledge.com/ck/application_store/content_store/ckb11-workforcedevt12004Sep10154722.pdf accessed 22/09/05.

Whittington, C. (2005) 'Interprofessional Education and Identity' in H. Colyer, M. Helme and I. Jones (eds) *The Theory-Practice Relationship in Interprofessional Education,* pp. 44-50 London: Higher Education Academy Health Sciences and Practice.

Whittington, Colin (forthcoming) "The Rise and Rise of Interprofessional Education?" in *Social Work: A Companion for Learning*, M. Lymbery & K. Postle (eds) London: Sage.

Whittington, Colin. and Holland, Ray. (1985) 'A Framework for Theory in Social Work', *Issues in Social Work Education* 5(1): 25-50.

Whittington, Colin and Whittington, Margaret (forthcoming) "Ethics and Social Care: political, organisational and inter-agency dimensions," in *Ethics: Contemporary Challenges in Health and Social Care*, A. Leathard and S. McLaren (eds), Bristol: Policy Press.

Worrall, A. (2005) "National Support for Clinical Governance," in *Clinical Governance in Mental Health and Learning Disability Services: A Practical Guide*, A. James, A. Worrall, & T. Kendall, (eds), London: Gaskell (Royal College of Psychiatrists) pp. 89-111.

4. Values, ethics, codes and social care governance

Policy and statute

Values are statements of belief about morally good or bad conduct (Clark 2000) and are a driving force both in governance and in social work and social care, as they are in the conduct of public administration more generally. The *Quality Standards for Health and Social Care* states a set of values and principles and declares its "first premise" as the belief that:

> "people in receipt of services should be actively involved in all decisions affecting their lives and should fully contribute to any planning for, and evaluation of, services." (DHSSPS 2005, p.6)

This section will refer to some dimensions of the value context of HPSS organisations, referring particularly to the Northern Ireland position before considering professional values in social work and social care and showing how some aspects relate to governance.

The significance of values in public administration is demonstrated by the review conducted in Northern Ireland as a prelude to major reform of structures in the public sector due to begin for HPSS organisations from 2007 (Secretary of State for Northern Ireland 2005). The review declares that:

> "it has placed equality, social need, human rights, good relations and rural issues at the heart of what is proposed and how the review has been conducted" (RPA Team 2005 para 10.2).

The review cites in particular Section 75 (1) and (2) of the *Northern Ireland Act* 1998, which came into force on 1st January 2000, and state respectively:

> "A public authority shall, in carrying out its functions relating to Northern Ireland, have due regard to the need to promote equality of opportunity:
>
> > (a) between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
> > (b) between men and women generally;
> > (c) between persons with a disability and persons without; and
> > (d) between persons with dependants and persons without."
>
> "Without prejudice to its obligations above, a public authority shall, in carrying out its functions relating to Northern Ireland, have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group."

Under Section 75, designated public authorities are required to submit Equality Schemes to the Equality Commission for Northern Ireland, to screen all policies, functions and duties as they relate to Northern Ireland and to carry out equality impact assessments of their policies where they are likely to affect the promotion of equality and good relations. Examples of schemes are published by a range of bodies in health and social care (Regulation and Quality Improvement Agency 2005; NISCC 2005; North and West Belfast Health and Social Services Trust 2001).

The aims of Section 75 underpin subsequent strategies, including *A Racial Equality Strategy for Northern Ireland 2005-2010* and *A Shared Future: Policy and Strategic Framework for Good Relations in Northern Ireland* (Office of the First Minister and Deputy First Minister 2005a ref 167; 2005b).

Values in social work and social care

The values described above are reflected in the professional values of social care and social work, being translated into descriptions or codes of required professional conduct. There are three sets of codes particularly associated with social work and social care practitioners. The primary code, encompassing all workers in UK social care, including social work, is:

- The Code of Practice for Social Care Workers

This is available in two forms, one setting out formally each requirement of the code and the other offering a more lay-friendly interpretation (NISCC 2002; GSCC 2005).

A further set of codes is published for members of the social workers' professional association:

- The Code of Ethics of the British Association of Social Workers (BASW 2003)

A third set, expressed as 'expectations' are part of the national occupational standards (NOS) that underpin the social work degree, and are based on consultations with service users and carers:

- The UK National Occupational Standards for Social Work: values and ethics statement of expectations (TOPSS 2004)

Analysis of the codes show them to be influenced by, and express, three streams of values (Whittington and Whittington forthcoming):

- a *traditional stream*, which promotes the ethic of personal service grounded in recognition of the value, uniqueness and intrinsic worth of every person, who deserves respect, confidentiality, self-determination and, where appropriate, protection

- an *emancipatory stream*, which expresses ideas of equality, justice, empowerment, anti-discrimination, respect for diversity, alliance with service users and carers and direct learning from them

- a *governance stream*, which is characterised by ideas of probity, partnership, accountability, risk management, consumer participation and choice, quality improvement and competent performance.

The ways in which the *governance* stream of values relates to corporate, clinical and social care governance will be obvious from earlier discussion but it may be more unexpected that aspects of the *traditional* and *emancipatory* streams are congruent with governance goals as well. For example, there is a widely recognised obligation to give an account of what one has done, or failed to do (Banks 2004).

This value of accountability has two dimensions. The first dimension is accountability to service users, which connects to the traditional value of respect for persons and to the emancipatory values of justice and empowerment. A second accountability is to the employing organisation and through it, to the wider public. This form is more tenuously linked to traditional and emancipatory streams of values, except through a democratic strand in emancipatory values. It represents more generally an adaptation to the typical organisational employment of social care workers and is part of the reciprocal obligations of employer and employee.

The picture is not one of unalloyed consensus, however. As described earlier, social care governance connects the *professional* and the *organisational* and attempts to bind them in a common enterprise. The goals of the two domains can sometimes conflict, for example over risk or budgets as determined by organisational targets and priorities. In those circumstances there may be pressure to subordinate traditional or emancipatory values of social care staff to managerially-led governance values. In anticipation, the BASW code requires social workers to carry out the aims of the employer, but only provided they are consistent with the traditional and emancipatory values that comprise the majority of the professional code. The Code of Practice for Social Care Workers is more muted, telling workers to inform the employer or appropriate authority if resource or operational difficulties get in the way of delivering safe care. By contrast, the NOS statement expects social workers to challenge their own organisation if necessary.

Such value tensions are a fact of organisational life and have to be negotiated by the managers and professionals involved in trying to operate governance systems. There are, however, clues from the focus groups with social care managers and staff as to possible lines of approach in reconciling professionally-led and managerially-led values.

For example, some staff described proliferation of paperwork and reporting priorities that got in the way of delivering a personalised service to users, conflicting with professional values and codes. Governance as characterised by these methods seemed merely burdensome. However, a different set of associations is offered by the quality-focused model introduced earlier and indicated in the focus groups. To draw briefly on some of the staff suggestions, this model would emphasise:

- reflective practice
- performance expectations and service standards matched realistically to resources
- risk management that clearly prioritises protection of service users and workers over reputational risk management
- a culture of learning not blame
- supervisory support and professional development
- clear goals of service improvement informed by the experience of front-line workers and service users.

These elements fit with the BASW value of proficiency in social work practice ('competency'), the NOS expectation of maintaining the knowledge to do the job, and the responsibility for improving work quality stated by the Code of Practice. The elements also fit with the idea of a 'learning organisation' able to take feedback and adapt its practices accordingly. Such a model resonates with the traditional and emancipatory values described. It suggests that governance systems are not inherently incompatible with traditional or emancipatory values.

Governance systems have been strongly influenced by professional and service failures and accordingly seek to avoid future failure; staff themselves have a clear interest in this purpose and will support it. However, the values of social care professionals look beyond harm-avoidance goals to the pursuit of enhanced quality and user empowerment. Governance models that seek to support these outcomes are additionally likely to gain their commitment.

Two further sets of ‘code’ deserve reference. The NISCC codes include a code of practice for employers (NISCC 2002). The obligations under the code support a quality-based model of social care governance:

Fig. 10 Items from the code of practice for employers of social care workers

- ensure that people are properly skilled and suitable for their post, understand their roles and responsibilities and are performance-managed to ensure high quality services

- have written policies and procedures that enable social care workers to meet their code of practice, supervising and supporting their performance and enabling them to report inadequate resources or operations that might impede safe care

- provide learning and development to enable skills and knowledge to be strengthened and extended

- have policies and procedures to deal with dangerous, discriminatory and exploitative behaviour and practice

- promote the staff and employer codes to staff and service users and carers, informing them about how to raise issues

Lastly, the *Quality Standards for Health and Social Care* themselves identify sets of values and principles that resonate with the social care values and codes described above and are formulated to underpin the kind of quality service that governance is intended to secure. The document expects managers and practitioners to base their practice on the values of dignity and respect, independence, service user rights, equal treatment and respect for diversity, choice, privacy, fulfilment of potential, confidentiality and safety. The *Standards* state that the right governance structures and processes are only part of the equation, and are secondary in securing a quality service:

> the most important premise is that "service users and carers [should] be fully valued by HPSS staff" (DHSSPS 2005, p.6).

References: Section 4

BASW (2003) *Code of Ethics for Social Work*, Birmingham: British Association of Social Workers http://www.basw.co.uk/articles.php?articleId=2 accessed 08/08/05.

Clark, C. (2000) *Social Work Ethics,* Houndmills Basingstoke: Palgrave.

DHSSPS (2005) *Best Practice, Best Care: The Quality Standards for Health and Social Care Consultation,* April http://www.dhsspsni.gov.uk/hss/governance/quality_standards.asp accessed 25/07/05.

GSCC (2005) *Rules for social care workers and their managers*, http://www.niscc.info/registration/pdf/Easy_Read_GSCC_Codes.pdf accessed 08/12/05.

NISCC (2002) *Codes of Practice for Social Care Workers and Employers of Social Care Workers* Belfast: NISCC.

NISCC (2005) *Equality Scheme: Drawn up in accordance with Section 75 and Schedule 9 of the Northern Ireland Act 1998*, http://www.niscc.info/about/pdf/Revised_Equality_Scheme.pdf accessed 03/08/05.

North and West Belfast Health and Social Services Trust (2001) *Equality Scheme*, http://www.nwb.n-i.nhs.uk/index2.html accessed 06/01/06.

Office of the First Minister and Deputy First Minister (2005) *A Shared Future: Policy and Strategic Framework for Good Relations in Northern Ireland*, http://www.asharedfutureni.gov.uk/pdf_documents/gprs.pdf accessed 17/01/06.

Office of the First Minister and Deputy First Minister (2005) *A Racial Equality Strategy for Northern Ireland 2005-2010*, http://www.ofmdfmni.gov.uk/race-equality-strategy.pdf accessed 19/08/05.

Regulation and Quality Improvement Agency (2005) *Draft Equality Scheme,* http://rqia.org.uk/site/equality.htm accessed 06/01/06.

RPA Team. "Initial Consideration of Equality, Social Need, Human Rights and Rural issues" in *Review of Public Administration in Northern Ireland: Further Consultation,* Chapter 10, http://www.rpani.gov.uk/consultdocu.pdf accessed 02/08/05.

Secretary of State for Northern Ireland (2005) *Statement by the Secretary of State for Northern Ireland on the Outcome of the Review of Public Administration,* 22 November, http://www.rpani.gov.uk/announce.pdf accessed 08/12/05.

TOPSS (2004) *National Occupational Standards for Social Work*, TOPSS England http://www.topssengland.net/files/SW%20NOS%20doc%20pdf%20files%20edition%20Apr04.pdf accessed 27/09/05.

Whittington, Colin and Whittington, Margaret (forthcoming) "Ethics and Social Care: political, organisational and inter-agency dimensions," in *Ethics: Contemporary Challenges in Health and Social Care*, A. Leathard and S. McLaren, (eds) Bristol: Policy Press.

Part Two: Quality Standards and Social Care Governance

This Part of the report develops the discussion begun in Section 2. Chief points of reference are the *Quality Standards* and the 'statutory duty of quality', which inform and help to legitimate the model of governance built here around 'quality' (DHSSPS 2005). Analysis of the *Standards* suggests that while the DHSSPS deems essential all the 'themes' in the Standards, the particular theme of 'safe and effective care' stands out as core. A second theme, 'accessible, flexible and responsive services' augments that core theme, elaborating on the style or modality of safe and effective care. Other themes in the *Standards* are read here as 'enabling' the achievement of safe and effective care. All the standards are informed by the principle of involvement of service users and carers.

Reference

DHSSPS (2005) *Best Practice, Best Care: The Quality Standards for Health and Social Care* Consultation, April. http://www.dhsspsni.gov.uk/hss/governance/quality_standards.asp accessed 25/7/2005.

5. Quality standards: core and enabling

Quality refers to the characteristics by which a service is judged. To recap, the key characteristics in the delivery of a quality service are taken in this report to be as follows:

Fig. 11 Characteristics of a quality service (1)

The service is:

- effective
- uses practices that are safe
- involves service users and carers

When essential points of reference are added, the characteristics are as shown in Fig. 12 below.

Fig. 12 Characteristics of a quality service (2)

1. *care outcomes* that are *effective* in meeting expectations of
    - service users and carers
    - agency objectives and social care values/codes

2. *care experiences* (care process) that are *effective* in meeting expectation
    - service users and carers
    - agency standards and social care values/codes

2. *care practices* that are *safe* for
    - service users and carers
    - staff
    - the public

4. *service users* and *carers* are *involved*

At the centre of the model of governance being developed here is, as explained earlier, the quality of the service being delivered. In that sense, it is firmly outcome-focused, embracing both the result and the process of care delivery as outcome experiences for the service user. The achievement and improvement of the quality outcomes (effective, safe, user-involved) depends upon having in place a series of ‘enabling’ elements, broadly, structures, practices, procedures and values that serve quality goals. *The combination of the key characteristics of a quality service with these enabling mechanisms will provides the basis for a model for social care governance.* It is suggested that the model is not relevant solely to social care but to joint arrangements for clinical *and* social care governance.

The core and enabling elements of the model are informed by the ‘Themes’ in the *Quality Standards* and are set out below. The enabling elements correspond to the four elements of social care governance introduced in section 3, earlier and elaborated in Figs. 13-18 and Part 3 to follow)

Core elements: delivery of quality care services

a) Core goals of a quality service to users and carers: effective care outcomes and experience; safe care practices; and user and carer involvement

b) Modality or style of quality services: the service is values-based, person-centred, community centred, equalities aware and resource-aware in service planning and service delivery

Four Enabling elements

Enabling elements represent sets of structures, procedures, practices and values, which serve the core elements. Four groups were identified in the discussion of ‘elements of social care governance’ in Section 3, namely: *engaging with key stakeholders*; *assuring quality and accountability*; *learning*; and *leading, managing and participating*.

Enabling element: engaging with key stakeholders

c) Partnership with service users and carers; and other agencies and professions

d) Communicating, informing and consulting service users and carers; staff; and other agencies and professions

Enabling element: assuring quality and accountability

e) Methods of assuring quality and accountability

Enabling element: professional and organisational learning

f) Learning from and applying training, cpd and research and the results and experience of engagement and quality assurance above

Enabling element: leading, managing and participating

g) Leading, managing and participating to develop, use and revise systems and structures for assuring quality, accountability and learning, to foster the quality culture and to secure resources

The governance activities comprised within the enabling elements may now be elaborated and are shown in Fig. 13. As illustrated in the Figure, the learning from the third element, *professional and organisational learning* should flow into the fourth element, *leading, managing and participating*.

Fig. 13 Enabling elements and activities of social care governance

Engaging with key stakeholders
• partnership with and involvement of service users and carers
• partnership with other professions and agencies
• communication and information to and from service users and carers
• communication and information within the agency and with other professions and agencies

Assuring quality and accountability
• Risk assessment, risk management and 'near miss' analysis
• Reporting of problems, latent issues and successes
• complaints and compliments management
• standards audit and case monitoring and review
• evidence-based practice
• staff supervision and performance management

Professional and Organisational Learning
• staff training and continuous professional development
• research including participation-based research
• learning from and applying the results and experience of quality assuring, partnership, information, training/development and research and reflections on the governance system

Leading, managing and participating
• developing, using ,reporting on and revising the systems and structures for engaging with stakeholders, assuring quality, accountability and professional and organisational learning
• fostering the quality culture
• securing and sustaining the human and other resources

6. A model of social care governance

In the following pages, the ‘core’ and ‘enabling’ elements a) to g) of social care governance outlined earlier are incorporated into a visual model of social care governance. The model is built up in stages using figs. 14-18.

Fig. 14 Elements a) core goals and b) modality

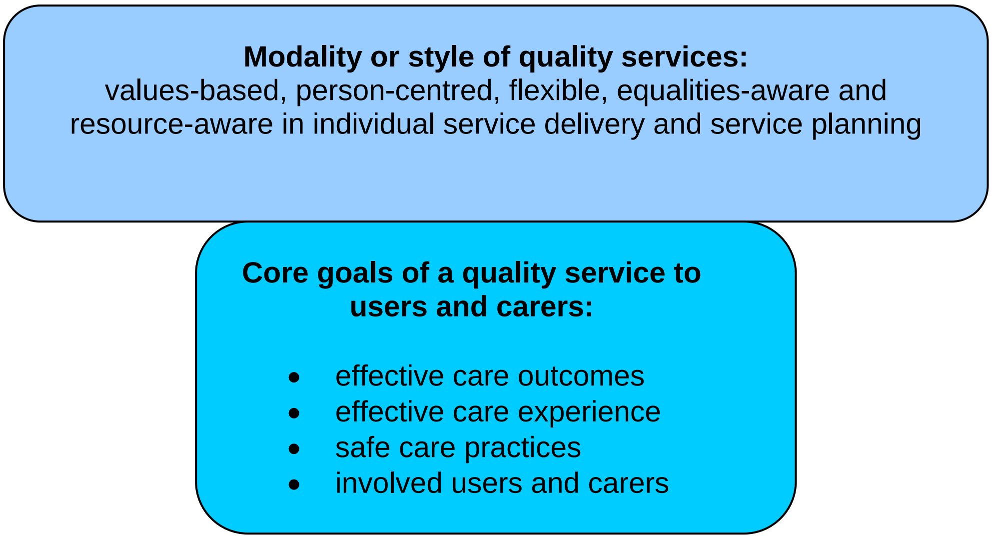


Fig. 15 Element added: c) partnership

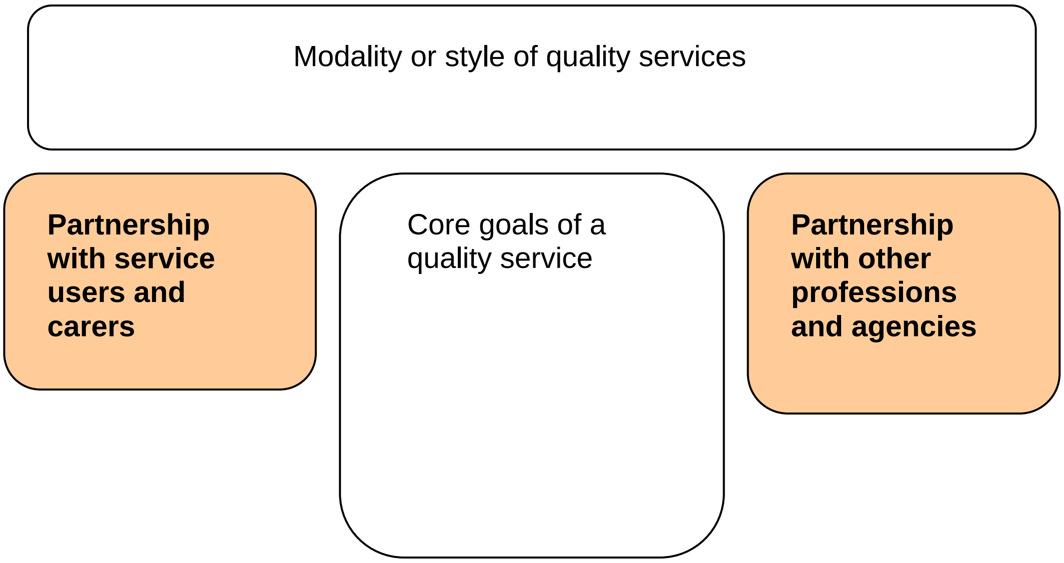


Fig. 16 Element added: d) communicating, informing and consulting

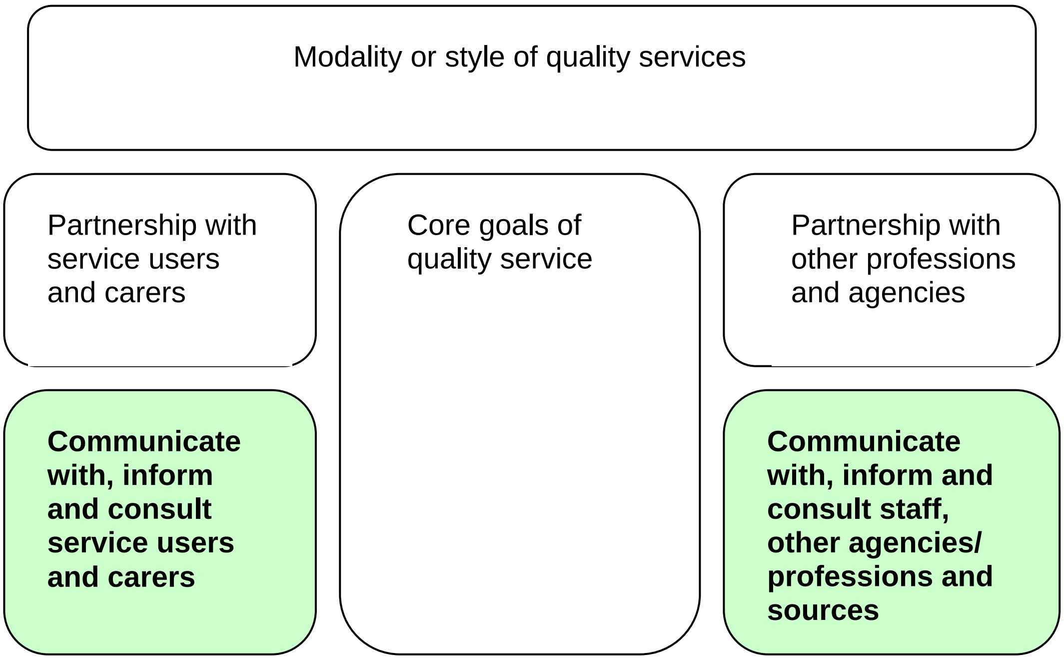


Fig. 17 Elements added: e) assuring quality and accountability f) learning and g) leading, managing and participating

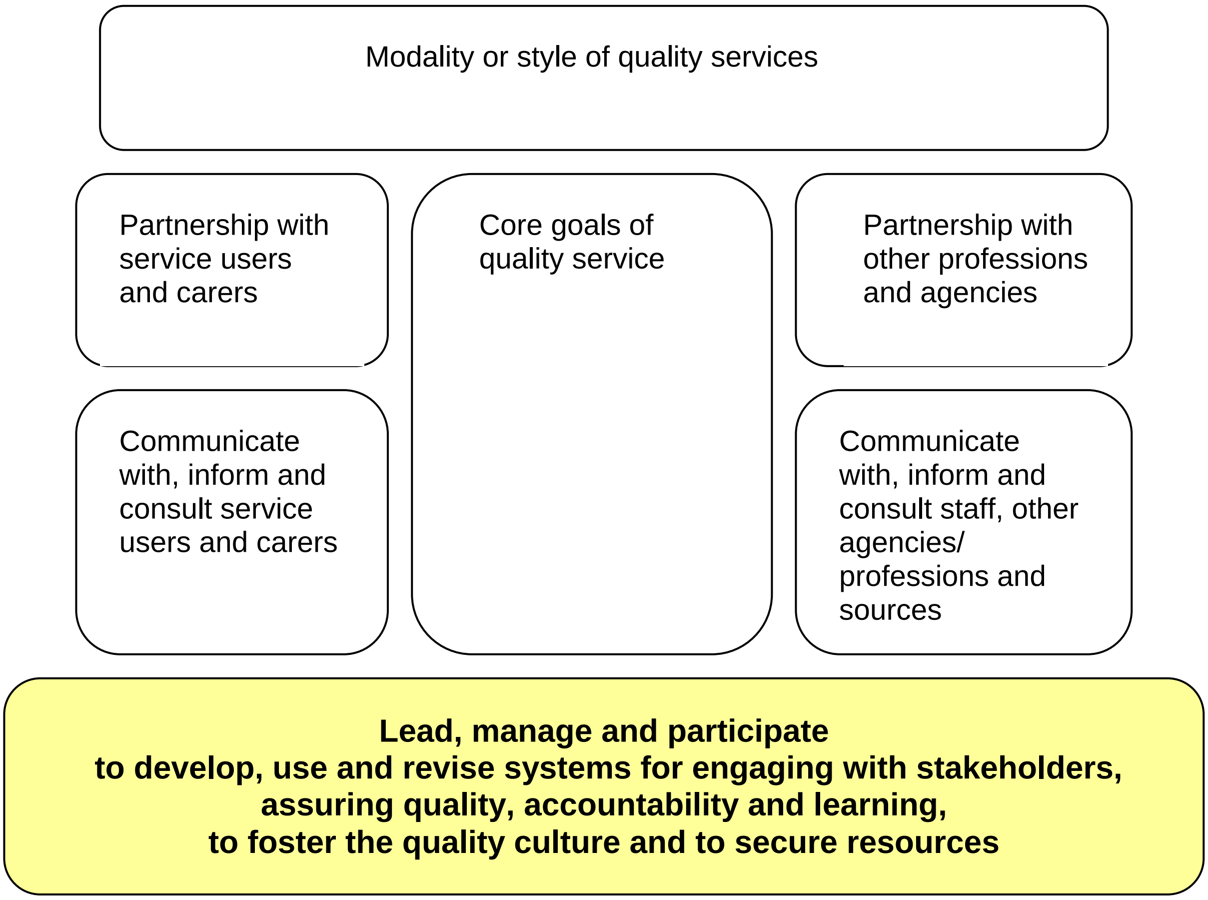
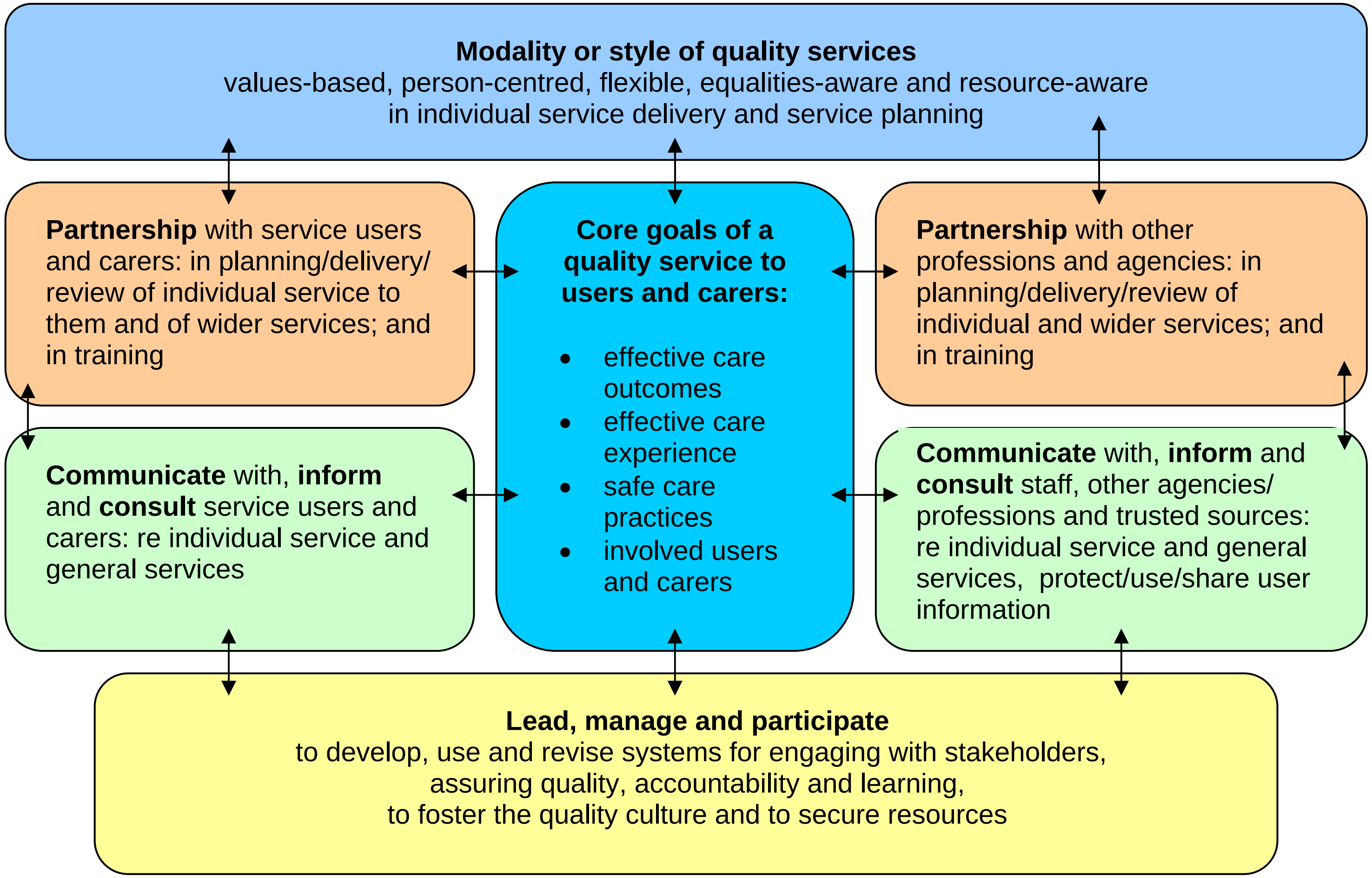


Fig. 18

A Model of Social Care Governance



Modality or style of quality services
values-based, person-centred, flexible, equalities-aware and resource-aware
in individual service delivery and service planning

Partnership with service users and carers: in planning/delivery/ review of individual service to them and of wider services; and in training

Core goals of a quality service to users and carers:

- effective care outcomes
- effective care experience
- safe care practices
- involved users and carers

Partnership with other professions and agencies: in planning/delivery/review of individual and wider services; and in training

Communicate with, **inform** and **consult** service users and carers: re individual service and general services

Communicate with, **inform** and **consult** staff, other agencies/ professions and trusted sources: re individual service and general services, protect/use/share user information

Lead, manage and participate
to develop, use and revise systems for engaging with stakeholders,
assuring quality, accountability and learning,
to foster the quality culture and to secure resources

Part Three Enabling Quality: Elements of Social Care Governance

Part Three concentrates on the ‘enabling elements’ of the social care governance model outlined in Section 5. There is no separate section on the ‘core elements’.   This report has made ‘a quality service to users and carers’ the centrepiece of its social care governance model but explication in detail of that quality service and its modality or essential style is not the function of the report. It is the province of other sources, namely: service and quality standards, knowledge and skills frameworks, practice guides, professional codes and values and, importantly, the perspectives of service users and carers. These sources are embodied among the key parties to the quality service, as described in Section 2, namely, service users and carers, social care staff, the HPSS organisation, its regulators and representatives of the public. Some aspects of the nature of a quality service from the user carer perspective do appear in the text but this is not the main purpose of the report.

Quality and the governance arrangements that seek to promote it have broadly two aspects: first, the *formal structural aspects* for managing and administering governance, such as the specified roles, procedures, reporting requirements, committee arrangements, development plans and time-frameworks of those involved; second, *relational aspects* involved in engaging with governance, participating in it and working with others to improve it (Whittington, B. 2005).   Both are indispensable parts of the whole, but holding the distinction in mind when planning, reviewing and operating governance arrangements is worthwhile for two reasons:

- to avoid concentrating on the absorbing question of formal structures at the expense of the relationships
- to gain attention for the relational aspects which are the dynamic source of governance systems, shaping how they work and delivering ideas for improvement and change

Involvement of service users and carers is treated here as having two broad dimensions: *partnership*, that is, active working together between service users and carers and service providing agencies and their staff, and contributions to *consultation* about the quality and development of services (see Carr 2004).

References: introduction to Part Three

Carr, Sarah (2004) *Has service user participation made a difference to social care services?* SCIE Position Paper No 3, London: SCIE.

Whittington, Brian (2005) Consultation meeting on governance implications of quality assurance experience in higher education, 9th December.

7. Partnership with service users and carers

> *"We urge HPSS organisations to recognise and value the experience that lives in service users and carers and to create the opportunities for the services to learn and gain from that experience"* (Service User and Carer Focus Group)

Three aspects of partnership are identified in this section and referred to in turn.

Partnership in planning, delivery and review of individual care

The first kind of partnership is about one's involvement in the social care service being personally received, such as:

- deciding what I need
- helping to decide what is needed by someone I help to care for
- having a say in what care is planned
- participating in the care that is provided
- commenting on whether the care experience or result was satisfactory

Partnership of this kind is underpinned by values of self-determination and empowerment. There are limits. Not all interventions are viewed as willing partnerships by the client and there may be conflict about objectives or, in some kinds of statutory duties, compulsion. Nevertheless, this aspect of partnership is fundamental to social care ethics and to a quality service and is a principle underpinning all the service-related versions of governance reviewed for this report. It should, where feasible, frame every encounter between the service provider and service users and carers.

Partnership refers to active participation but recognises that:

- different service users and carers may seek different levels of engagement

- involvement levels and capacity may vary over time

- users and carers may have different as well as complementary interests, and

- they bring different contributions to the partnership

(Service User and Carer Focus Groups).

The partnership knowledge and skills required are part of the requirements of the social work degree and should be included in the training for social care staff (NISCC 2003). This partnership approach to practice has to be designed into care standards and care systems, from referral to conclusion, and the resource implications have to be calculated, both in terms of investment costs and benefits.

Service user and carer focus groups advised that they should be involved at all stages, with regular opportunities to review that the service is meeting the current need. They stressed that *all* professions involved in the care process should recognise the principle of partnership and that it should extend to both the service user *and* carer. A coordinated team approach is incomplete without regarding service user and carer as part of that team (Service Users and Carers Focus Groups).

These sentiment are echoed in the Northern Ireland Carers' strategy which argues that, "to achieve genuine partnership the following principles should be incorporated into every planning process where there is a carer involved:

- identification of the carer with the main service user should be undertaken at the beginning of the process;
- identify the individuals who will provide services;
- the expertise of the carer should be recognised and respected;
- the expertise of the professional should be acknowledged and accepted;
- the legal/medical framework within which professionals have to operate
- should be recognised;
- information which is pertinent to the caring role should be shared;
- there should be consultation and negotiation about the type of support
- the carer feels they need and how this will be provided; and
- the carers situation should be reviewed periodically and changes to the
- level and type of support negotiated" (DHSSPS 2006, pp.45-6).

Partnership in planning and delivery of care services

The second kind of involvement is to do with the whole service, such as:

- helping the Trust to get a picture of how the service is working
- having a say in the planning or improvement of a service

The numbers and types of local partnerships have grown in the last ten years across the UK and in Northern Ireland where they include regeneration partnerships, local strategic partnerships and neighbourhood renewal. The experience has brought a realisation of the strengths and weaknesses of this growth (Bound *et al* 2005):

- partnerships are an important tool for community engagement
- partnership proliferation can lead to too many strategies that are not joined up while creating strain if those involved have to wear too many hats.

Examples of partnership include involvement on governing boards, as described by Hasler in her study of the Care Councils in Northern Ireland and elsewhere in the UK (Hasler 2003) and the developing concept of service user councils as illustrated in Fig. 19 (please see also "A Note on examples…", p.16 check page).

Fig. 19 Example: service user council advertisement

Service Users Council Member and Carer Council Member

Are you interested in working with us to improve Mental Health Services in Hertfordshire?

…we are looking for knowledgeable and enthusiastic Service Users and Carers of Hertfordshire to create a Service User Council and a Carer Council that will help HPT develop mental health services that are more Service User/Carer focused.
As a Service User or Carer Council Member, you will ensure that the voice of the Service Users and Carers is heard within the Trust on important issues, including strategy, policy and service development. In return the Trust will offer regular training and support to Council Members together with individual support from the Service User and Carer Involvement Lead.

There will be remuneration of £30.00 per three-hour session plus travel/alternate care expenses.

extract from online advertisement for Hertfordshire Partnership Mental Health Trust

http://www.hertsviewpoint.co.uk/documents/Council%20advert.pdf

The example is part of the policy of a 'beacon authority' in England and its service user involvement action plan identified through work with mental health service users by the Hertfordshire Partnership Trust (HPT). This was developed from the 2005 National Patient Survey, a service user workshop and service user questionnaire. The Action Plan is reviewed and monitored by the HPT Service User Involvement Steering Group each month. The objectives of the plan are shown in Figure 20.

Fig. 20 Example: Objectives of the service user involvement action plan

Areas for implementation and development include involvement in:

- formal governance roles such as the user council
- planning and policy development
- delivery of front-line services
- provision of information
- staff recruitment and selection
- training
- complaints, comments and compliments
- advocacy
- audit and clinical effectiveness including design, collection and analysis

Further areas for development include:

- remuneration for service users
- employment of service users
- ensuring representation of black and minority ethnic groups and of specialist groups and services such as drug and alcohol services

(Hertfordshire Partnership Mental Health Trust 2005)

Partnership with service users and carers raises debates about representativeness, which may be motivated by the desire for a full range of views or to cast doubt on unpopular contributions. Doubts about representativeness are countered by the view that all community participation is a valuable resource (Bound *et al* 2005). However, some groups do tend to be under-represented, as the final point in the HPT example above implies, and there is recognition by organisations like Shaping Our Lives that work is needed to understand and counter this tendency by developing diversity of involvement (SOL 2005a ref 361). There is also a need for practical guides to help make events accessible and to provide ground rules for meetings (SCIE 2005; SOL 2003; SOL 2005b).

Guides from the Council for Disabled Children and Contact a Family show parents and professionals how public policy on user participation can be translated into something that is meaningful for parents and children (2005). Beresford also advises professionals on how to make service user involvement real by paying attention to inclusion and diversity, ensuring that involvement makes a positive difference and creating involvement in the areas where users themselves believe they can make the biggest difference (Beresford 2002).

Discussion of service user and carer participation has tended to focus on adults but there is growing acceptance of the right and ability of children and young people to participate in the change and improvement of social care services. This development is addressed in a SCIE guide (Wright *et al* 2005). The guide provides advice on four aspects of development needed by organisations to achieve effective involvement. These areas, which are transferable to involvement with other groups, are to develop:

- a culture of participation
- a structure for participation
- effective practice for participation
- effective systems to review participation

Although partnership and consultation, respectively, are discussed in different sections of this Part of the report to distinguish their different types and levels of engagement, they stand on a continuum and share issues (as in the previous paragraph). Similarly, much that stands as good practice in one activity is also good practice in the other. This point is illustrated in Carr's advice on what to think about when planning service user participation (Carr 2004). Further examples of advice on good practice are included in Section 9.

Partnership in training of staff and service users and carers

The Northern Ireland strategy for carers identifies training needs on a number of levels (DHSSPS 2006):

- training for carers as carers
- training for carer advocates in relation to complaint-making
- training for front-line staff in responding to complaints
- training for service users and carers in training of professional staff

Service users and carers in the focus groups welcomed the idea of involvement in staff induction, training and consultation roles, arguing that partnership in these areas meant proper briefing and training of service users and carers as well. It is anticipated that these dimensions will feature in the service user participation strategy commissioned by Skills for Care to address the contribution of service users to training and workforce development in social care (Skills for Care 2005).

There is already an expectation on social work degree programmes that service users should be involved (NISCC 2003). A SCIE guide prepared by Enid Levin examines how service users, carers and providers of social work education and training can work together. The guide It describes the principles, practicalities and range of approaches to building and sustaining these partnerships. The key messages of the guide "apply also to developing service users' and carers' involvement in all types of training for social work and social care staff and in the design and delivery of services" (Levin 2004). Adjacent professions such as psychiatry are committed to similar work (McClure 2005).

A further guide, addressed primarily to higher education but also seeking to speak to agencies and Trusts, recognises that service users and carers are a growing part of in-house training in some agencies (Tew 2004). In line with this development, service user and carer focus group members sought training and briefing themselves in training and consultation roles.

Examples of research and theoretical work

As well as practical guides, there is also a developing research and theoretical literature on partnership with service users and carers in governance. Pickard researched involvement of users in clinical governance in primary care groups and trusts, arguing for clarity about roles and the matching of participants' experience to the governance questions under consideration (Pickard 2002). Newman discusses the nature and constraints upon 'collaborative governance' aimed at encouraging more active citizenship and creating more user-responsive services (Newman 2004). Barnes discusses the unwritten practices and rules that can affect engagement of service users in participative forums. She shows the way in which expectations of 'rational debate' can exclude the emotional content of the experience of living with mental health problems from discussion about mental health policy (Barnes 2002).

Sang theorises three principles for effective involvement of service user involvement drawn from the literature on clinical governance (2006):

- informed dialogue
- triangulation
- shared learning about risk

To adjust the language slightly for social care governance, 'informed dialogue' means developing a mutual understanding of the model of governance being used and the values, objectives and evidence-base adopted. 'Triangulation' rests on the idea that the performance goals of governance and the wider public legitimacy it seeks, depend on validating the process from three complementary perspectives: professional peers, service users and service partners. 'Shared learning about risk' means setting aside mythology about the predictive quality of professional knowledge and the achievement of risk-free care services. A mature partnership with service users and carers, (and eventually with 'the public'), means developing an ability to be open about risks, professional uncertainties and lack of knowledge. Sang offers these three principles as a basis for achieving an effective and trusted system of governance.

A further measure for enhancing trust and effectiveness in governance models is the evaluation of partnership with service users and carers: whether it is taking place, what works best and why.

References: Section 7

Barnes, M. (2002) “Bringing difference into deliberation? Disabled people, survivors and local governance”, *Policy and Politics* 30 3, pp. 319-331.

Beresford, P. (2002) “Making User Involvement Real”, *Professional Social Work* June, pp. 16-17.

Bound, Kirsten, Carley, Michael, Harrison, Julie, Skidmore, Paul and Winckler, Victoria (2005) *Mapping Governance at the Local Level*, York: Joseph Rowntree Foundation.

Carr, S. (2004) *Has service user participation made a difference to social care services?* SCIE Position Paper No 3, London: SCIE.

Council for Disabled Children and Contact a Family (2005) *Parent Participation: guides for parents and for professionals*. Information Leaflet, http://www.cafamily.org.uk/index.html accessed 05/01/06.

DHSSPS (2006) *Caring for Carers Recognising, Valuing and Supporting the Caring Role* *http://www.dhsspsni.gov.uk/publications/2006/caring_for_carers.pdf* accessed 12/01/06 .

Hasler, F. (2003), *Users at the Heart: User participation in the governance and operations of social care regulatory bodies,* London: SCIE.

Hertfordshire Partnership NHS Trust Mental Health Services (2005) HPT Service User Involvement Strategy Action Plan for 2005/2006.

Levin, E. (2004) *Involving Service Users in Social Work Education*, London: SCIE.

McClure, M. (2005) *Partners in Care Training Resource*, 2005. London: Gaskell/Royal College of Psychiatrists. (Ref ID: 273)

Newman, J. (2004), "Public participation and collaborative governance", *Journal of Social Policy*, 33, 2, pp.203-233.

NISCC (2003) *Northern Ireland Framework Specification for the Degree in Social Work*, http://www.niscc.info/careers/pdf/SW_framework_spec_0303.pdf accessed 6/4/2006.

Pickard, S. (2002) "User involvement in clinical governance", *Health Expectations*, 5, 3, pp.187-198.

Sang, B. 2006, "Fixing the broken triangle: improving patient and public involvement in clinical governance, locally and nationally," in *Clinical Governance in a Changing NHS*, M. Lugon & J. Secker-Walker (eds), London: Royal Society of Medicine, pp.19-33.

SCIE (2005) *How to make events accessible,* *http://www.scie.org.uk/publications/misc/accessguidelines-events.pdf* accessed 19/01/06.

Skills for Care & Hartlepool Partners (2005) *Consultation with Service Users to Improve Participation in Skills for Care*. http://healthbase.tees.ac.uk/sfcusersurvey accessed 23/08/05.

SOL (2003) *Guidelines for Making Events Accessible*, http://www.shapingourlives.org.uk/ accessed 19/01/06.

SOL (Shaping Our Lives) (2005a) “Shaping Our Lives National User Network Newsletter” Issue 8 - December 2005, http://www.shapingourlives.org.uk/ accessed 05/01/06.

SOL (2005b) *Ground Rules for Meetings, http://www.shapingourlives.org.uk/* accesses 19/010/06.

Tew, J., Gell, C., and Foster, S. (2004) *Learning from Experience: Involving service users and carers in mental health education and training,* HEA/NIMHE/Trent WDC.

Viewpoint service user involvement project (2005). *Find out about the HPT service user Council*. http://www.hertsviewpoint.co.uk/latestnews_article.php?id=14 ; http://www.hertsviewpoint.co.uk/documents/Council%20advert.pdf accessed 19/01006.

Wright, P., Turner, C., Clay, D., & Mills, H. (2005) *Involving Children and Young People in Developing Social Care,* SCIE Practice Guide 6, http://www.scie.org.uk/publications/practiceguides/participation/index.asp accessed 05/01/06.

8. Partnership with other professions and agencies

“It is important to work towards services that are more joined-up across Trusts and other agencies and services” (Service User and Carer Focus Group).

Governance and the quality service it aims to assure, take place in an ‘open system’, that is, an environment in which the plans and activities of particular professions and agencies are affected by, and increasingly depend on, other professions and agencies. The ability to practice collaboratively and develop effective partnerships is required of modern HPSS organisations both at the higher corporate or strategic level and at the service delivery or operational level of social care governance. Collaboration is also required whether structures are well integrated or less well-integrated. Figure 21 summarises the point.

Fig. 21 A matrix of collaborative structures (adapted from Whittington 2003a p.27)

	Less integrated	**More integrated**
Strategic	Separate services linked in a multi-agency network	Integrated H&SS Trust
Operational	Staff of different disciplines co-operating across team & agency boundaries	Inter-disciplinary team

The injunction to cooperate comes from many sources:

- Service users and carers:

  The focus group quotation above reiterates the views of other service users who want social care staff to work effectively with others in obtaining and providing services (Audit Commission 2000). User complaints to the Ombudsman “often expose problems in joint working between public service providers” (Health Service Ombudsman 2004, p.13).

- Care and protection policies:

  Collaboration is central in implementing services for effective care and protection of children, vulnerable adults and the public (DHSSPS 2005a; DH 2000; Lewis 2003; Ritchie 1994; Secretaries of State 2003).

- Wider ‘modernisation’ policies:

  Effective staff collaboration and agency partnership are significant factors in delivering the UK Government’s broader strategic goals of effectiveness and modernisation across sectors (RPA Team 2005; DHSSPS 2005b).

Partnership with other professions and agencies can be thought of in three areas:

- Planning, delivery and review of individual care

- Planning, delivery and review of (general) care services

- Partnership in training

Staff focus groups commented that partnership working needs to be underpinned by:

- a culture of collaboration
- shared understanding of roles and responsibilities between professionals and agencies
- procedures that support and show requirements for inter-agency cooperation
- development opportunities for staff in multi-disciplinary and multi-agency working

Guidance on workforce development opportunities in this area are set out in a CareKnowledge on-line briefing. The briefing offers action points drawing on experience in England in multi-disciplinary and multi-agency services (Whittington 2003b).

The connection between partnership with other professions and partnership with service users and carers was made by one of the focus groups who recorded:

> “multi-disciplinary teams need to move beyond the professionals and directly involve service users and carers.”

In common with partnerships with service users, mechanisms are needed to evaluate collaboration and partnership with other professions and agencies: whether they are taking place, what works best and why. Partnership is not a panacea. Local public bodies are urged by the Audit Commission to be constructively critical of the partnerships they form, asking themselves questions about the purpose of the partnership, how partnership working adds value and what the mechanisms are for accountability and governance (Audit Commission, 2005). Some models and methodologies for integration and partnership are accessible online. There are also tools to assist in the assessment of partnership and for thinking about the balance of breadth and depth to be struck in developing relationships with partners (Every Child Matters 2005; Glasby 2005; Integrated Care Network 2006; Nuffield 2003; Whittington 2003c).

References: Section 8

Audit Commission (2002) *Integrated Services for Older People: Building a Whole System Approach in England,* London: Audit Commission.

Audit Commission (2005) *Governing Partnerships: Bridging the Accountability Gap,* London: Audit Commission.

DH (Department of Health) (2000) *No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*, London: Department of Health.

DHSSPS (2005a) “Review of Health and Social Services in the case of David and Samuel Briggs (summary of issues)” Belfast: Department of Health, Social Services and Public Safety.

DHSSPS (2005b) *Best Practice, Best Care: The Quality Standards for Health and Social Care Consultation,* April http://www.dhsspsni.gov.uk/hss/governance/quality_standards.asp accessed 25/07/05.

Every Child Matter (2005). *Multi-agency working,* http://www.everychildmatters.gov.uk/deliveringservices/multiagencyworking/ accessed 21/11/05.

Glasby, J. (2005) “The Integration Dilemma”, *Journal of Integrated Care,* 13, 5.

Hardy, Brian., Hudson, Bob, & Waddington, Eileen (2003) *Assessing strategic partnership: the partnership assessment tool*, ODPM http://www.nuffield.leeds.ac.uk/downloads/pat.pdf accessed 03/03/05.

Health Service Ombudsman for England (2004) *Annual Report 2003-04*, London:TSO.

ICN (Integrated Care Network) (2006) Website of the Integrated Care Network http://www.integratedcarenetwork.gov.uk/homepage.php accessed 11/01/06.

Lewis, R. J., Cole, D., & Williamson, A. (2003) *Review of Health and Social Services in the Case of David and Samuel Briggs*. Belfast: DHSSPSNI.

Ritchie, J. H., Dick, D., & Lingham, R. (1994) *The Report into the Care and Treatment of Christopher Clunis,* London: HMSO.

RPA Team (2005) *Review of Public Administration in Northern Ireland: Further Consultation* March http://www.rpani.gov.uk/consultdocu.pdf accessed 02/08/05.

Secretaries of State for Health and the Home Department (2003) *The Victoria Climbié Inquiry: Report of an Inquiry by Lord Laming,* Norwich: HMSO.

Whittington, Colin (2003a) "Collaboration and Partnership in Context," in *Collaboration in Social Work Practice*, J. Weinstein, C. Whittington, & T. Leiba, (eds), London: Jessica Kingsley, pp.13-38.

Whittington, Colin (2003b) *Social Care Workforce Development for Multi-Disciplinary and Multi-Agency Services*, CareKnowledge Briefing No 11, http://www.careknowledge.com/ck/application_store/content_store/ckb11-workforcedevt12004Sep10154722.pdf accessed 22/09/05.

Whittington, Colin (2003c) "A model of collaboration," in *Collaboration in Social Work Practice*, J. Weinstein, C. Whittington, & T. Leiba, (eds), London: Jessica Kingsley, pp.39-61.

9. Communicating with, informing and consulting service users and carers

Communication is no longer simply written or verbal but involves multiple and expanding media. This growth is accompanied by expansion in both the communication opportunities and issues to be considered by public authorities. The value of different types and points of information access for service users and carers is offset in some instances by inequalities arising, for example, from sensory disabilities, different skill levels and different levels of access to information technology. Communication policies have to take these factors into account.

Critical factors in effective communication include (Trevithick *et al* 2004):

- clarity and accuracy
- skill in choosing and using the language of the recipient
- understanding and accommodating specific communication needs of the recipient
- having effective communication channels

As mentioned in Section 7, the commitment to improve communication with service users and carers is found in official documents re-designed specifically for lay audiences (GSCC 2004), advice on how to produce information in an accessible way (SCIE 2004) and guides on how to make events accessible (SCIE 2005). A recent website on the service user experience illustrates the growing importance attached to informing the approach to service users and carers (CGST 2006).

Considerable expertise in defining and communicating information exists among groups run for and led by service users and carers themselves such as Carers Northern Ireland (2006) and Shaping Our Lives and is growing among professional organisations (Partners in Care 2006).

The second strand of communication considered in this section is from service users and carers to service providers. The service user and carer focus groups held to inform this report gave particular attention to information and consultation issues. Extracts from the groups are given below.

Communication of individual service information to service users and carers

Service users and carers said:

- ensure staff are well-briefed in what services are available and how to get them

- actively ensure that the people are aware of what services are available by telling them and having accessible written information (like a summary card, key contact numbers, service specialists and web site)

Communication of general service information to service users and carers

Service users and carers said:

- information is everything! Share it, using plain language and avoiding jargon
- provide good clear practical information, such as the local example of a practical guide for families who have a relative entering care
- provide accessible 'signposting' of services to make it easy for people to get information about services, as illustrated by a local service information leaflet

Consultation with and service feedback from service users and carers

Service users and carers said:

- have a clear plan to enable carers to be involved in advising on services and giving feedback
- convene user and carer forums
- people have different experience and different contributions to make to the processes of involvement. Match these contributions to different kinds of involvement at the personal level and the service consultation level.

Consulting on the particular service received

Service users and carers said:

- consult on the experience of the service regularly (not just during external inspections)
- include a random element to consultation to avoid any suspicion that consultation is biased towards those who have had a good experience
- bear in mind that service users and carers may be wary/worried in case what they say adversely affects them and the service subsequently received – have methods that overcome this anxiety

Consulting for service, review and planning

Service users and carers advised

- establish credibility of the consultation: provide information on purpose and process, avoiding tokenism and impressions of merely a paper exercise, assuring that decisions have not already been made and that there will be clear outcomes

- involve service users and carers early, prepare them, and make clear that all feedback whether positive or negative will be accepted without recrimination

- be realistic about what can be achieved

- recognise that in groups where service users and carers are in a numerical minority, it can be hard to make the user or carer voice properly heard

- examine recruitment criteria and procedures for any in-built discrimination that repeats selection by 'establishment' criteria and job style entry procedures which screen out many people
(Equality Commission 2006)

- consider the effect of timing and locality of meetings on access and give full weight to the commitments of service users and carers

- take account of the different needs and abilities of participants (e.g. sensory, language, cultural, learning and physical differences) and have a variety of feedback and commentary methods

- valued and respect service user and carer experience by aiming for equality of access and expenses, providing for administrative costs or access (e.g. to computers), remuneration, and arrangements for time off work to attend key meetings/consultations

- recognise that organised groups may not be the only people with an interest

- ensure that there is an outcome to the consultation with Trust and Board involvement, give feedback and let users and carers see the final document or decision

- seek to consult in ways that generate useful information on the quality and distribution of services across the region

- "good news stories are needed so let's share what works well".

Focus group advice on handling complaints is reported in section 11.

Service users and carers also advised that their experience of consultation should be systematically *reviewed and evaluated*. An example of a review procedure has been developed in a county's Adult Care Services where the 'having your say' policies and procedures include a satisfaction evaluation with service users including comparisons of satisfaction ratings over time (Farrer 2005).

References: Section 9

Carers Northern Ireland (2006) *Information*, http://www.carersni.org/Information accessed 06/01/06.

CGST (2006) *Welcome to the Patient Experience Team web pages*, http://www.cgsupport.nhs.uk/Patient_Experience/default.asp accessed 06/01/06.

Equality Commission for Northern Ireland (2006) *Equalities Law, http://www.equalityni.org/yourrights/equality_law.htm* accessed 23/01/06.

Farrer, Jean (2005) "'Have your say' procedure" Hertfordshire Adult Services.

GSCC (2005) *Rules for social care workers and their managers*, http://www.niscc.info/registration/pdf/Easy_Read_GSCC_Codes.pdf accessed 08/12/05.

Partners in Care (2006) *Three new checklists for carers, patients and doctors*, http://www.partnersincare.co.uk/ accessed 06/01/06.

SCIE (2005) *How to make events accessible*, http://www.scie.org.uk/publications/misc/accessguidelines-events.pdf accessed 19/01/06.

SCIE (2005) *How to produce information in an accessible way,* http://www.scie.org.uk/publications/misc/accessguidelines-publications.pdf accessed 19/01/06.

Trevithick, P., Richards, S., Ruch, G., Moss, B., Lines, L., and Manor, O.(2004) *Teaching and learning communication skills in social work education,* London: SCIE.

10. Communicating with, informing and consulting staff, other agencies and professions

The chief dimensions of communication relevant to this section are:

- communication and consultation among staff within the team and Trust, and between practitioners and managers

- communication and consultation with other professions and agencies on individual care provision

- communication and consultation with other professions and agencies on care services more broadly

- the use of information from trusted sources to inform individual cases, service development and improvements in the evidence-base of practice

It is not possible to develop these themes in detail here but they plainly deserve detailed attention. Further reference to in-house communications and to sharing of good practice will be made in section 11. It is worth repeating, meanwhile, that critical factors in effective communication include (Trevithick *et al* 2004):

- clarity and accuracy
- skill in choosing and using the language of the recipient
- understanding and accommodating specific communication needs of the recipient
- having effective communication channels

The present section and Section 9 connect implicitly with the subject of information governance. It will not be explored here but detailed developments are in progress, for example, under the Information for Social Care policy. This policy defines information governance as relating to the Data Protection Act 1998, the Freedom of Information Act 2000, The NHS Confidentiality Code of Practice, Information Security Management, and records management (IfSC 2004). Related developments include a proposed information sharing index to support the work of children's services in all areas of England by the end of 2008 (Every Child Matters 2005).

Developments involving the sharing of information and remote access raise questions about privacy and control of access. These have been familiar issues in all HPSS organisations where the tensions between the need for corporate record-keeping and professional ethics of confidentiality are recurrent. Large scale, networked records systems raise the debate to new and challenging levels (NHS Confidentiality Code 2003; SSIW 2005).

While protection of service user information is an important issue, service user and carer members of the project focus groups were concerned with other dimensions of information use as well. They argued the importance of:

> “ensuring good records to assist continuity and avoid service users and carers having to repeat information to successive workers.”

Service users and carers also advocated:

> “good sharing of information so that things don’t start from scratch with each new ‘worker’ or contact with a different member of the multi-disciplinary team”.

Practical suggestions by the staff focus groups concentrated on reducing delays in interprofessional and cross- agency communication and reducing duplication of questions to service users and carers:

- enhance communication by linking all staff by email
- work to harmonise assessment and review processes and recording systems
- clarify and manage confidentiality issues

Good communication within the agency, and recognition that it needs time, was seen to underpin effectiveness in social care by staff focus groups. This principle included the communication of clear policies and procedures. The point leads to the next section.

References: Section 10

Department of Health (2003) *Confidentiality Code of Practice*, http://www.dh.gov.uk/assetRoot/04/08/06/80/04080680.pdf accessed 05/01/06.

Every Child Matters Website (2005) *The Information Sharing Index*, http://www.everychildmatters.gov.uk/deliveringservices/index/ accessed 07/01/06.

IfSC Information Policy Unit (2004) *Social Care Information Governance: Briefing Paper*, http://www.dh.gov.uk/assetRoot/04/08/29/57/04082957.doc accessed 23/01/06.

SSIW/NHSW (Social Services Inspectorate for Wales/NHS Wales) (2005) *Confidentiality: code of practice for health and social care in Wales. Welsh Assembly Government Guidance on Sharing of Information and Confidentiality*, Cardiff: SSIW.

Trevithick, P., Richards, S., Ruch, G., Moss, B., Lines, L., and Manor, O.(2004) *Teaching and learning communication skills in social work education,* London: SCIE.

11. Assuring quality and accountability

The work of Trusts and their practitioners are conducted with reference to sets of standards and codes derived at a number of levels. For example:

- *UK-wide*: NHS Knowledge and Skills Framework (DH 2004); Social Care Codes of Practice (NISCC 2002); BASW Code of Ethics (2003); Investors in People (2004).
- *National/Regional: Best Practice Best Care: The Quality Standards for Health and Social Care* (2005); safeguards for the protection of children and vulnerable adults (POCVA 2003)
- *Standards particular to a service or Trust:* devised at organisational level, or at team level, for example, stating quality standards for dealing with referral, allocation or risk assessment.
- *Nationally and locally relevant findings* from DHSSPSNI inspections and reviews

Standards, codes and inspection findings provide benchmarks for planning and delivering services and for quality assurance and accountability for which, in turn, a number of methods have been developed. Examples of these methods are included in the discussion of governance activities below.

References: introduction to section 11

BASW (2003) *Code of Ethics for Social Work*, Birmingham: British Association of Social Workers http://www.basw.co.uk/articles.php?articleId=2 accessed 08/08/05.

DH (Department of Health) (2004) *The NHS Knowledge and Skills Framework (NHS KSF) and Development Review Process*, http://www.dh.gov.uk/assetRoot/04/09/08/61/04090861.pdf accessed 01/11/05.

DHSSPS (2005) *Best Practice, Best Care: The Quality Standards for Health and Social Care Consultation,* April http://www.dhsspsni.gov.uk/hss/governance/quality_standards.asp accessed 25/07/05.

IIP (Investors in People) (2004) *Unlock Your Organisation's Potential*, http://www.investorsinpeople.co.uk accessed 29/11/05.

NISCC (Northern Ireland Social Care Council) 2002 *Code of Practice for Social Care Workers*, Belfast: NISCC.

Protection of Children and Vulnerable Adults (Northern Ireland) Order. Statutory Instrument 2003 No. 417 (N.I.4). Office of Public Sector Information.

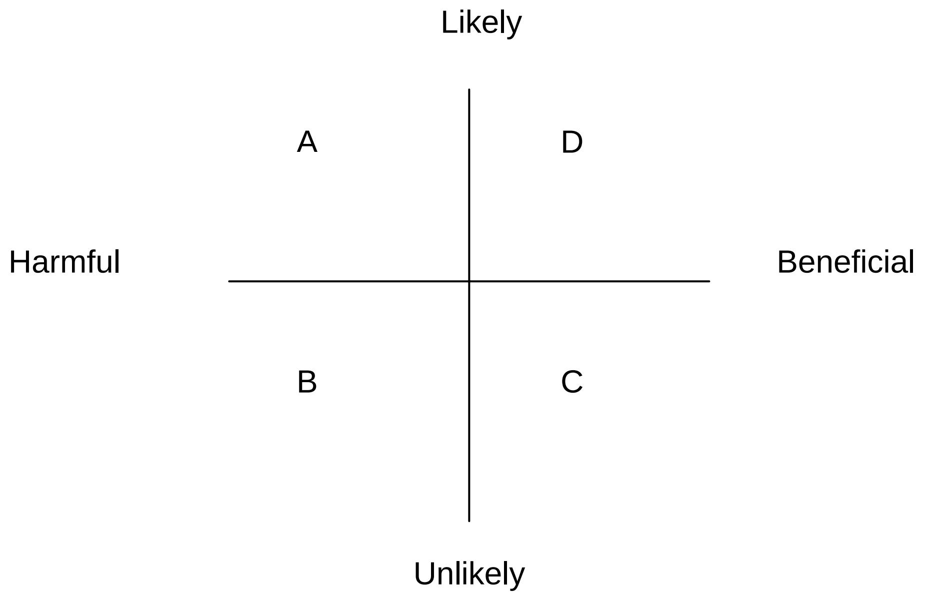
Risk assessment, risk management and 'near miss' analysis

A significant failing in the case of David and Samuel Briggs was lack of awareness of risk factors at management and operational levels in the Trust (DHSSPS 2005a). The aim of protection against risk is enshrined in 'controls assurance' by which HPSS bodies provide evidence that "they are doing their reasonable best to manage themselves so as to meet their objectives and to protect users, staff, the public and other stakeholders against risk of all kinds" (DHSSPS 2002). Risk can be defined as:

> "…the possibility of beneficial and harmful outcomes, and the likelihood of their occurrence in a stated timescale" (Alberg *et al* in Titterton 2005).

A basic picture of risk assessment gives a matrix having two dimensions that comprise the degree of likelihood of a given outcome (risk estimation) and its degree of harm or benefit should that outcome occur (risk evaluation) (Titterton 2005).

Fig. 22 Risk matrix



(Adapted from HAS 2001)

The aim of risk *assessment* is to identify where risks fall within the matrix. The aim of risk *management* is to devise strategies that will help to move risks away, especially, from the A quadrant towards the progressively more desirable quadrants at B, C and D. More elaborate risk rating matrices are available and come with both official endorsement and a caveat that organisations should determine for themselves which method works best (DHSSPS 2005b).

An enlarged idea of risk management based around what the authors call 'safeguarding incidents' refers to "organisational processes that promote learning from mistakes as a means to improve safety for service users and carers" (Bostock *et al* 2005). The research-based approach uses methods pioneered in aviation and since adapted to health care and advocated for child protection. The approach introduces ideas of 'near misses' and no-harm incidents when things *almost* go wrong. Learning from these 'free mistakes' can prevent future mistakes that would cause real harm. Near misses arise when (Bostock *et al* 2005):

- something could have gone seriously wrong but did not
- something did go wrong but without serious harm in this case

The 'safeguarding incident' approach is focused on two aspects addressed in the model of governance adopted in the present report: *safe care practices* and *learning*. Bostock and colleagues found few opportunities in children's care organisations to learn from near misses or to use that learning to improve safe care practices. Where learning does occur, "it is located at the frontline, in supervision between social workers and their managers". (Bostock *et al* 2005). An organisational, and inter-agency approach is needed.

Bostock and colleagues recommend a number of steps towards learning from safeguarding incidents:

- introduce near miss reporting systems and forums

- develop techniques for understanding what leads to near misses

- enlist the knowledge and expertise of service users and carers

- explore how best to promote an open and blame-free approach to learning from safeguarding incidents

- develop a practitioner network to promote good practice in complex decision-making.

Most models of risk assessment come with a caveat that it is not possible to eliminate the complexity and variability of human situations that have to be judged. Research with social work and health professionals by Brian Taylor confirms that professionals face complex and sometimes contradictory issues when translating risk management strategies into practice. The professionals respond by using, not a single approach to conceptualising risk and its management, but a number of approaches which reflect their efforts to balance the pressures to do what is defensible with what is 'right' (Taylor, forthcoming).

The pressure on public authorities to adopt defensive strategies in risk management has been highlighted by recent reports (Power 2004). Attempts to counter these tendencies are found in models such as the person-centred risk assessment and management system (PRAMS) (Titterton 2005) and the urging of some service users who seek non-paternalistic models of care (DH 2005). These alternatives do not reject the idea of risk assessment and management but introduce calculated *risk-taking* which may be defined as:

> A course of planned action based on informed decisions in which the potential benefits of the action, or inaction, outweigh the potential harms.

HPSS organisations and their staff face a challenging task in resolving these different imperatives. Examples of policies on protection of vulnerable people and assessment and management of risk show the complex task in creating forms and procedures that comprehensively cover the issues (South and East Belfast HPSS Trust 2003). Staff focus groups heard of practical measures in some Trusts to combine procedures of risk assessment with ongoing monitoring and review and to embody a multi-disciplinary dimension.

References: sub-section on risk assessment, risk management and 'near miss' analysis

Bostock, L., Bairstow, L., Fish, S., and Macleod, F. (2005) *Managing risk and minimising mistakes in services to children and families,* London: SCIE.

DH (2005) *Responses to the consultation on adult social care in England Analysis of feedback from the Green Paper: Independence, Wellbeing and Choice*, http://www.careknowledge.com/ck/application_store/content_store/ASGResponse041216242005Oct21103645.pdf accessed 28/10/05.

DHSSPS (2002) *Risk Management in the Health and Personal Social Services HSS (PPM) 8/2002*. www.dhsspsni.gov.uk/hss/governance/documents/circular_hss_(ppm)_8_2002.doc, accessed 22/08/05.

DHSSPS (2005a) "Review of Health and Social Services in the case of David and Samuel Briggs (summary of issues)" Belfast: Department of Health, Social Services and Public Safety.

DHSSPS (2005b) *HPSS Guidance on analysis of risk and risk rating matrix,* . www.dhsspsni.gov.uk/hss/governance/documents/guide_riskregister_matrix.pdf accessed 22/08/05.

HAS (Hertfordshire Adult Services) (2001), *Adult Risk Assessment and Risk Management*.

Power, M. (2004) *The Risk Management of Everything* Demos www.demos.co.uk/ riskmanagementofeverything_pdf_media_public.aspx accessed 07/01/06.

South and East Belfast Health and Social Services Trust (2003), *Procedures for the Protection of Vulnerable Adults from Abuse and Exploitation*.

Taylor, B. J. (forthcoming) "Risk Management Paradigms in Health and Social Services: Professional Decision Making on the Long Term Care of Older People", *British Journal of Social Work*.

Titterton, M. 2005, *Risk and Risk-taking in Health and Social Welfare,* London: Jessica Kingsley.

Reporting of problems, latent issues and successes

This aspect is included to recognise that beyond the more obvious active failures and near misses there is a further order of phenomena that have implications for the quality of the service: it consists of problems, puzzling and 'latent' issues and also practice successes, all of which need formal channels through which they may be discussed and communicated.

Research on risk and failure shows a tendency to concentrate on active failures and on frontline staff and service users and carers. Despite the commitment in governance principles to explore all possible risks to organisational objectives, 'latent failures' that are embedded in the system and create condition for active failure, receive less attention. "Latent failures are associated with the actions and decisions of those not in the frontline, such as politicians and policy-makers, senior management and designers…. Making the system safer may require change at any level, not just those close to service-user contact." (Bostock *et al* 2005)

The NISCC code of practice for social care workers expects workers to inform the employer or appropriate authority of resource or operational difficulties that might get in the way of the delivery of safe care. Social care workers must similarly make it known when the practice of colleagues may be unsafe or adversely affect standards of care (NISCC 2002). Employers are expected to have mechanisms to enable these duties to be undertaken. These expectations are part of a spectrum that extends to a requirement of a 'whistle-blowing' policy in HPSS organisations, which is underwritten by *Northern Ireland Public Interest Disclosure Order*, 1999 and for which the DHSSPS is the formal regulator.

Whistle-blowing occupies a very small element of HPSS activity. Organisation that wishes to learn as much as possible about ways of improving the quality of services will also create arrangements for identifying, sharing and working on practice problems, incidents for understanding risk, puzzling and latent issues and, importantly, the successes of practitioners, managers and teams.

Complaints and compliments management

Best practice principles for complaints management in Northern Ireland are provided in a 2003 report (Southern Area/DHSSPS 2003). Complaints and their importance are given due weight but the report adds that a process should be available to allow suggestions, comments or compliments to be made and followed up. A contributor said:

> "There needs to be further development of a system for recording compliments because we always dwell on the negative."

The report notes that complaints within the HPSS follow two main procedures:

- HPSS Complaints Procedure
- Children (NI) Order Representation and Complaints Procedure

Complaints and criticisms were considered in the service users and carers focus groups of the project, resulting in the following advice:

- have good complaints procedures and use them
- be receptive and recognise that complaints come for a reason
- recognise the service user's and carer's unique experience
- respond to complaints personally not by abstract, written replies.

References: sub-sections on reporting of problems, latent issues and successes and complaints and compliments management

Bostock, L., Bairstow, L., Fish, S., and Macleod, F. (2005) *Managing risk and minimising mistakes in services to children and families,* London: SCIE.

NISCC (Northern Ireland Social Care Council) 2002 *Code of Practice for Social Care Workers*, Belfast: NISCC.

Southern Area/DHSSPS (2003) *Report on Good Practice Review of Complaints Procedures in the HPSS* (led by Southern Area on behalf of DHSSPS), http://www.dhsspsni.gov.uk/econsultation/Good_practice/Final_report_SHSSSB.pdf accessed 24/01/06.

Standards audit and case monitoring and review

All of the methods in the present Section 11have explicit or implicit elements of *accountability* - literally, the responsibility and process for giving an account of one's decisions and actions. Accountability contributes to observance of standards by practitioners, managers and organisations and is part of the code of practice and ethical code of social workers and care workers. It is a particular feature of *standards audit* and of *case monitoring and review*.

Use of terminology varies and there is no absolute arbiter of meaning. It is important therefore to seek clarity of meaning and intention in any given situation. *Audit* is taken here to mean, typically, checking against defined standards or targets. The practice frequently involves a cycle of defining the standard or target, observing practice and gathering relevant information, evaluating practice against the standard and planning change before setting new standards or targets. The audit may be personal, that is by the individual practitioner, internal, by the supervisor or other member of the organisation, or by external authority.

Monitoring and review generally refer to case-focused methods. Monitoring oversees progress against a plan to ensure that work is on track and proceeding satisfactorily; review involves looking again at the needs of the situation and action being taken, prior to continuation or redirection. Service reviews have a wider, corporate scope.

Staff focus groups viewed audit, monitoring and review as essential to quality and stated that they must be meaningful in having an outcome:

- for service user, carer and care worker

- directly or cumulatively, for the whole service.

The outcome, they said, should include clear feedback to stakeholders on how the product of the review is achieving a better quality service.

Staff focus groups listed the purposes of monitoring and review as ensuring:

- service user gets the right service
- the quality is good
- the service reflects changing needs
- the services are required
- the resources/budgets are well and appropriately used
- the assessment of risk is up to date
- critical issues are flagged for more detailed review
- there is equity and equality in services and in the right to comment on them.

Staff focus groups stated the following characteristics of good quality audit, monitoring and review processes:

- they identify what evidence is needed, conveying priorities and standards
- they should encompass quality as well as quantity
- they should have scope for both objective and subjective indicators

These injunctions resonate with research that points to the persistent tendency over many years of performance indicators and audit methods to focus on quantity and efficiency at the expense of quality and effectiveness (Whittington 1988; Munro 2004). This is not an inevitable effect and the clear emergence of the *Quality Standards* provides a strengthening basis for audit and review closer to the aims of service users and carers and professionals.

Some Trusts have developed procedures that aim to combine audit, monitoring, review and research functions. One example given in the focus groups is a local procedure in mental health that seeks to capture what had been done, the decisions made and the reasons.

Staff focus groups advised that audit, monitoring and review methods are more effective if they:

- are easy to understand and, where appropriate, useable by different professions

- yield reliable information and provide accountability but do not unduly use contact time needed with service users and carers

- build-in consultation with service users to verify that the findings of reporting systems are reliable and valid.

Some staff in the focus groups reported positive experience of involvement of front-line workers and service users and carers in designing procedures and forms advocated:

- involvement in the design of the review process
- tailoring methods to service user preferences and needs
- making review content and conclusions subject to service user endorsement
- being sensitive to the wording and its impact on the service user and carer

An underlying requirement for effective audit, monitoring and review is good records management. DHSSPS guidelines are available in *Good Management Good Records: Guidelines for Managing Records in Health and Personal Social Services Organisations in Northern Ireland* (DHSSPS 2004)

Staff focus groups reflected on the possible outcomes of case monitoring and review, which are:

- no change
- need for increased or additional service
- reduction or ending of the service

The first and particularly second of these have resource implications. Where it is hard to sustain or increase provision, the monitoring and review processes become indicators of need:resource ratios more than quality tools.

Staff focus groups also commented on the importance of connecting individual case review to wider quality issues. A group participant described the practice in one Trust, noting its value and also the need to allocate time to the process:

- review information is gathered in relation to individual service users
- it is systematically review by managers/other staff for wider implications
- there is a consultative process involving front-line staff, other disciplines and service users
- feedback is given to parties on resulting decisions/changes.

The staff focus groups cited local audit-related examples. In one, a method of case file auditing was initially not welcomed by staff yet in practice it proved beneficial to them and won their support.

References: sub-section on standards audit and case monitoring and review

DHSSPS (2004) *Good Management Good Records: Guidelines for Managing Records in Health and Personal Social Services Organisations in Northern Ireland,* http://www.dhsspsni.gov.uk/dhs-goodmanagement.pdf accessed 31/10/05.

Munro, E. (2004) “The Impact of Audit on Social Work Practice*”, British Journal of Social Work,* 34, 8.

Whittington, Colin (1988) “Literature Review: The Efficiency and Performance Assessment Debate”, *British Journal of Social Work* , 18, 2, pp.201-212.

Evidence-based practice

The different methods assuring quality and accountability in social care governance need to connect if the model is to be effective. This is no more true than for the connection between learning from risk and near misses and the evidence base that practitioner use. This principle has implications for the HPSS organisation and for its relationship with partners.

> “Modern services require an integrated approach between the various agencies providing social and health care, and this in turn calls for each agency to have a well developed evidence base for its interventions. Put very simply, integrated care will be hindered if social care cannot participate with its sister agencies in basing common policies and practices on evidence.” (Marsh and Fisher 2005)

The idea of evidence-based practice raises a number of issues:

- the nature of the knowledge or evidence to be applied and how it was produced
- how practitioners are to access the evidence
- what can be done to help them use it to inform practice

The idea of evidence-based practice tends to polarise opinion among both researchers and practitioners (Freshwater and Rolfe 2004; MacDonald 1999; Trinder and Reynolds 2000; Smith 2004). The debate polarises along a number of dimensions: first, between the assumptions and methods of ‘scientific’ approaches to producing evidence, characterised for instance by the testing of medicines, versus ‘humanistic’ approaches; second, between the priorities of the different stakeholders, that is, between professionals or service providers versus service users, and between managers versus front-line workers (Marsh and Fisher 2005). The introduction of evidence-based ideas into social work and social care comes with a warning to avoid narrow definitions of the nature of knowledge and not to rigidify the relationship between knowledge and practice (Fisher 2002).

There are three chief routes by which practitioners and managers may access evidence relevant to practice:

- professional self-development including reading and reflection on one’s work
- organised professional training and development
- agency-based development.

All three and especially the first will be assisted by efforts to develop a reading culture in practice settings. Horder observes that this is relatively undeveloped and is partly explained by the strong oral culture among practitioners. Practitioners need support in determining what to read and in accessing texts. Horder argues that the growth of electronic media offers opportunities to overcome lack of reading but that their use needs skills which also require support and development (Horder 2004).

The academic benchmarks of professional training required for the Social Work Degree expect the “critical application of research knowledge from the social and human sciences (and closely related domains) to inform understanding and to underpin action, reflection and evaluation (QAA 2000). Practitioners undertaking the Advanced Post-qualifying Award must “provide evidence of significant contribution to the development, delivery and evaluation of the service provided in a chosen area by demonstrating the ability to research, plan, implement, monitor and evaluate strategies for improvement or change" (NISCC 2002). Related sources include the report: "Promoting Research and Evidence-Based Practice: From Rhetoric to Reality" (NISCC 2002) and an emerging range of evidence-based texts (McAuley, 2006).

Agency-based development consists of providing the opportunity in-house to research and reflect on practice, to access written sources and to participate in forums for exchange. One example is the 'Northern Ireland Best Practice Scheme' (Public Service Reform Unit 2005). In tune with this, members of the staff focus groups argued that practice should be informed by learning from research and the experience of others. Opportunities and information need to be systematically available, they said, to managers and practitioners to update and apply the evidence-base of practice.

Staff focus group participants gave examples of:

- Approved social workers meeting regularly to discuss practice issues, share information and consider required changes or development

- Family and Child Care staff at a Trust sharing good practice and experience of more and less effective practices

Staff focus group members recommended:

- more opportunities for sharing *across* Northern Ireland, to gain knowledge and development of good practice and consistency
- opportunities focused at practitioner and first-line manager levels
- support of a Northern Ireland-wide strategy that seeks to develop policies and good practices that are locally relevant but apply broadly across the province.

Materials to help the process of informing practice include work on improving the use of research (Walter et al 2004), using systematic reviews (Macdonald 2003), guidance on appraising research (Sheppard 2004) and standards for evaluating knowledge (the TAPUPA approach) (Pawson et al 2003). The Northern Ireland 'good practice reviews' also aim to support the process in specific practice areas (DHSSPS 2006).

References: sub-section on evidence-based practice

DHSSPS (2006) *Good Practice Review on Complaints Procedures, User Involvement, Access to Information, Promoting Positive Staff Attitudes to Diversity* http://www.dhsspsni.gov.uk/equality/practice.asp accessed 24/01/06.

Fisher, M. (2002), "The Social Care Institute for Excellence: the role of a national institute in developing knowledge an practice in social care", *Social Work and Social Sciences Review*, 10, 1.

Freshwater, D. and Rolfe, G. (2004) *Deconstructing Evidence Based Practice.* London: Routledge.

Horder, W. (2004), "Reading and Not Reading in Professional Practice", *Qualitative Social Work*, 3, 3, pp.297-311.

Macdonald, G. (2003), *Using Systematic Reviews to Improve Social Care*, SCIE Reports No 4, London: SCIE.

Macdonald, G.(1999) "Evidence-based social care: wheels off the runway?", *Public Money and Management* 19, 1, pp.25-32.

Marsh, P. and Fisher, M. (2005) *Developing the evidence base for social work and social care practice.* SCIE Using knowledge in social care: Report 10.

McAuley, Colette, Pecora, Peter J. & Rose, Wendy (eds) (2006) *Enhancing the Well-being of Children and Families through Effective Interventions: International Evidence for Practice,* London: JKP.

NISCC (2002) *Promoting Research and Evidence-Based Practice: From Rhetoric to Reality*, http://www.niscc.info/pdf/research.pdf accessed 07/12/05.

NISCC (2002) *Requirements for PQ and Advanced Awards in Social Work http://www.niscc.info/pdf/req_awards_0502.pdf* accessed 07/12/05.

Pawson, R., Boaz, A., Grayson, L., Long, A., & Barnes, C.(2003), *Types and Quality of Knowledge in Social Care,* London: SCIE.

Public Service Reform Unit (2005) *Northern Ireland Best Practice Scheme Information and Details of Forthcoming Events.* http://www.bestpracticeni.gov.uk/bestpracticescheme.pdf accessed 08/12/05.

Sheppard, Michael (2004) *Appraising and Using Social Research in the Human Services: An Introduction for Social Work and Health Professionals*, London: Jessica Kingsley.

QAA (Quality Assurance Agency) (2000) *Subject Benchmarks: Social Work*, http://www.qaa.ac.uk/academicinfrastructure/benchmark/honours/socialpolicy.asp accessed 07/12/05.

Smith, D.E. (2004) *Social Work and Evidence-Based Practice*, Research Highlights 45. London: Jessica Kingsley.

Trinder, L. and Reynolds, S. (2000), *Evidence-based Practice: A critical appraisal* Oxford: Blackwell.

Walter, I., Nutley, S., Percy-Smith, J., McNeish, D., and Frost, S. (2004), *Improving the use of research in social care practice*, Knowledge Review 7, London: SCIE.

Staff supervision and performance management

Supervision is part of the bedrock of learning and practice in social work and social care and one established forum for the matters described in the preceding sub-section. There is an extensive literature on *'staff supervision'. Social Care Online* returns well over 400 records (http://www.scie-socialcareonline.org.uk/default.asp) and learning materials are available from the Skills for Care leadership and management project (SfC 2005).

Staff focus groups gave supervision particular attention in considering means by which service quality may be assured. They described its purposes and benefits as including:

- accountability, case monitoring and review
- consistent management of safe practices
- maintaining standards of practice, recording and ethics
- teaching and learning
- performance review and personal development planning
- supporting and helping the worker
- picking up key practice issues e.g. assessing and managing risk
- a forum for either party to raise issues or concerns

This perspective is endorsed and expanded in published analyses (Smyth, Simmons and Cunningham 1999). Suggestions on supervision policy from the staff focus groups included:

- consult supervisees on the model of supervision and consider the interests in the model of other stakeholders inside the agency and outside, including service users and carers
- in addition to the individual supervisee-supervisor model, models include
    - peer group supervision with facilitator
    - team and multi-disciplinary team supervision (group)
- supervision should take place at defined regular intervals with discretion for some limited, negotiated variation around a standard
- record and agree supervision decisions (supervisee-related and case-related) between supervisor/supervisee
- use supervision, including group supervision as a channel for evidence to inform practice

Staff support is an important part of supervision and was picked out by focus group participants as a significant factor in achieving a quality service. Managers, they said, need:

- the time to listen and respond
- competence in managing social work and social care
- where appropriate, competence in managing multi-disciplinary teams

- ability to help staff in managing workloads and discretion to limit excessive loads

A strategic *performance management* framework was proposed in the *Best Practice Best Care* consultation under plans for monitoring the performance of HPSS organisations (DHSSPS 2001). The term is also applied to operations and encompasses the relationship between supervisor and practitioner and supervisor and teams. Guidance encourages organisations to recognise the interaction between comprehensive corporate assessment and performance management (IDeA 2006a).

Models of performance management generally approximate the version outlined by the Chartered Institute of Personnel and Development (IDeA 2006b; CIPD 2006). Performance management incorporates performance improvement and development. It depends on establishing a culture of personal and shared responsibility for the improvement of services and of the skills and contributions of staff. Expectations are clarified and shared reciprocally between managers individuals and teams concerning the work and expected performance. It is therefore a joint process. It is a planned process involving defined expectations expressed as objectives and measurement of progress on objectives.

The tools of performance management of individuals and teams generally include the following:

- agreed objectives
- performance standards or competencies
- measures, such as the ‘balanced scorecard’, which looks at performance from the perspectives of different stakeholders
- reflection on past performance
- learning and development planning
- coaching

Implicit in this list is the need for structures to support performance management although the CIPD advocates some flexibility to allow people freedom to operate. Performance management is defined as a process, not an event. It is conceived to operate as a continuous cycle.

The CIPD suggests that individuals and managers value the performance management emphasis on personal development. However, performance-rating linked to pay often provokes hostility. Schemes can also require too much form-filling and be over-detailed yet lack of definition of what is meant by performance and how to achieve it. Schemes need clarity of expectations, training for those involved and convincing evidence that quality service and professional benefit will result (CIPD 2006).

References: sub-section on Staff supervision and performance management

CIPD (Chartered Institute of Personnel and Development) (2006) *Performance Management*, http://www.cipd.co.uk/subjects/perfmangmt/general/perfman.htm accessed 25/01/06.

DHSSPS (2001) *Best Practice Best Care A framework for setting standards, delivering services and improving monitoring and regulation in the HPSS*, http://www.dhsspsni.gov.uk/publications/2001/4161contentsintro.pdf accessed 21/08/05.

IDeA (2006) *The performance management improvement journey, http://www.idea-knowledge.gov.uk/idk/core/page.do?pageId=1292577*, accessed 01/02/06.

IDeA (Improvement and Development Agency) (2006) *Review of Performance Improvement Models and Tools,* http://www.idea-knowledge.gov.uk/idk/aio/1551334 accessed 01/02/06.

SfC (Skills for Care) (2005) *Manage effective supervision: a unit of competence for managers in social care, http://www.topssengland.net/view.asp?id=494* accessed 11/01/06.

Smyth, C., Simmons, L., and Cunningham, G. (1999), *Quality Assurance in Social Work: a standards and audit approach for agencies and practitioners* NISW, London.

12. Professional and Organisational Learning

It was said earlier that the categories of social care governance are not watertight. Indeed, it is important that they flow into one another since what is being described is a system, not rigidly separated structures. Accordingly, parts of the foregoing discussions have already referred to matters that will be cited in this section under 'learning'. A separate section devoted to the heading of learning is justified by the importance of *professional* and *organisational* learning in the achievement of quality.

Three aspects of learning are worthy of development in a model of social care governance: staff training and continuous professional development; research; and learning from the operation of the governance model.

Staff training and continuous professional development

Aspects of this have already been described. It is important to register that this area covers more than *knowledge* about practices that are effective or not. The area encompasses learning of new and changing *skills* and new understanding of *values*, along with the relationship of knowledge, skills and values three. It is also important to register that learning must to go on at all levels of the organisation.

Service user and carer focus groups expressed a clear interest in staff learning. They said that Trusts should

> "ensure that staff are competent for the roles and tasks they are given, and provide ongoing training and development".

Service users and carers made clear that competence means here, knowing about the services and how to obtain them and also, importantly, listening, respect, sensitivity, openness and truthfulness, working in partnership and wherever possible, proceeding by agreement.

Staff focus groups included the following in the purposes and benefits of staff development:

- developing the practitioner's and manager's skills and understanding of role
- developing staff use of quality and accountability systems
- acting on learning needs identified elsewhere, including in supervision
- helping in understanding boundaries between their role/responsibilities and those of others
- contributing to a more effective use of time and a better service
- conveying that the agency values the staff member
- raising staff morale and self-esteem

Systematic development, sometimes connected to performance management systems, may be pursued using a personal development plan (PDP). A PDP cycle is described in the NHS Knowledge and Skills Framework (KSF) (DH 2004, Ch. 3):

- defining learning and development needs with reference to the job and a strategy for meeting them
- supported learning and development
- joint evaluation of learning and application
- joint review against demands of the job and agreed targets and objectives…continuation of the cycle.

Types of learning and development opportunities are given in the KSF (p.39), together with forms for mandatory development review and PDP (Appendix 7).

The social work postqualifying framework has an important part to play in individual staff development. Corporately, some HPSS agencies use *Investors in People* (IiP) to underpin staff learning programmes and to provide defined standards to improve organisational performance (IiP 2004). Health Quality Service (HQS) accreditation and Charter Mark awards are also pursued by some trusts. IiP covers:

- developing strategies to improve performance
- taking action to improve performance
- evaluating the impact on performance

Notably, IiP advocates asking staff whether investment in them is making a difference to their performance.

As the staff focus groups observed, governance itself introduces new learning needs, concerned with understanding its purpose and methods and contributing to its development. Portfolios are being developed in some settings to assist in this process (NIMTDA & NICSCGT 2005).

References: sub-section on staff training continuous professional development

DH (Department of Health) (2004) *The NHS Knowledge and Skills Framework (NHS KSF) and Development Review Process*, http://www.dh.gov.uk/assetRoot/04/09/08/61/04090861.pdf accessed 01/11/05.

IIP (Investors in People) (2004) *Unlock Your Organisation's Potential*, http://www.investorsinpeople.co.uk accessed 29/11/05.

NIMTDA & NICSCGT (2005) *Practice Clinical and Social Care Governance Portfolio*. Belfast: NICSCGT.

Research including participation-based research

Research is essentially a learning activity. It refers here to:

- research as a corporately-sponsored process within or between HPSS organisations and also to
- research undertaken by individuals within the organisation, with its support, sometimes as part of post-registration development (Alston and Bowles 2003).

In both cases, a growing dimension is the participation of service users and carers, not only as respondents but in some instances as participants in research design and implementation.

The active collaboration of researchers with the social care workforce is also seen increasingly as a key development.

> “Rather than simply seeking to enlighten a workforce portrayed as reluctant to engage in and to use research, more progressive approaches within social work research seek a collaborative partnership with the community of practitioners, identifying their research priorities, how new knowledge can be integrated with existing practice (or can most effectively challenge existing practice), and testing the day-to-day feasibility of interventions.” (Marsh and Fisher 2005)

Reference: sub-section on research…

Alston, Margaret and Bowles, Wendy (2003) *Research for Social Workers: An introduction to methods*, London: Routledge.

Marsh, P. and Fisher, M. (2005) *Developing the evidence base for social work and social care practice.* SCIE Using knowledge in social care: Report 10.

Learning from and applying the results/evaluation and experience of quality assuring, partnership, information, training/development and research

This third dimension might be expressed in a shorthand term: 'learning organisation' (SCIE 2004; Gould and Baldwin 2004). It performs two important tasks. First, it registers the 'stakeholder engagement' and 'assuring quality and accountability' dimensions of social care governance described above, namely:

- partnership with service users and carers and with other professions and agencies
- communication and information to and from service users and carers, within the agency and with other professions and agencies
- assuring quality and accountability measures
- staff training and cpd
- research

Secondly, it takes these activities of social care governance and underlines that:

- they should be recognised as rich sources of learning
- the learning content should be drawn out and its service improvement implications identified
- the service improvement implications should inform practice and service planning

It is the function of the following, final element of the social care governance model, 'leading managing and participating', to provide the conditions under which this set of learning imperatives are realised.

References: sub-section on learning from and applying the results/evaluation and experience…

SCIE (2004) *Learning Organisations: a self-assessment resource pack,* London: SCIE.

Gould, N. and Baldwin, M. (2004) *Social Work, Critical Reflection and the Learning Organization,* Aldershot: Ashgate.

13. Leading, managing and participating

This element represents the fourth group of ‘enabling’ activities in social care governance. The element addresses three sets of activities related to: structures and systems, quality culture and resources. Each set of activities requires leadership, management and participation.

Leadership is needed to develop and implement social care governance systems. Managers have a key role in the process but others may also give a lead on the basis of their expertise and creativity. Participation appears in the list because of its significance in the model of social care governance proposed: it registers the importance of wide ownership among staff and of giving responsibility and opportunity to all members of staff in the pursuit of a quality service.

In discussing this set of ‘enabling’ activities, it is timely to be reminded of the twin aspects of social care governance identified earlier: first, the formal governance structures and, second, the relational aspects, which are the dynamic source of governance systems, shaping how they work and delivering ideas for improvement and change.

Developing, using, reporting on and revising the following: systems and structures for engaging with stakeholders, assuring quality and accountability, and learning

This set of activities is, first, about getting the design of the social care governance arrangements right. Second, it is about using the learning from the operation of the arrangements to review and revise them and the service itself. Third, it involves reporting on systems, process and outcomes.

Concerning design, staff and service users and carer focus groups, said that great value will come from attention to the infrastructure which, if ‘fit for purpose’, will underpin and facilitate a quality service. Focus groups advised under a number of headings, which are shown below:

- clear policy and strategies

    - on social care governance for quality
    - on safe practices for staff and service users and carers and on verbal and physical abuse of staff
    - equalities and diversity in respect of service users and staff

- brief and train staff on governance policy and implementation

- standards and procedures

    - translate standards and results of inspections into workable operational form

    - have clear organisational and inter-agency procedures for quality and accountability that are amenable to review and revision in light of experience
    - have protocols for service user and carer involvement
    - establish inter-agency and interprofessional agreements on partnership and sharing information
    - seek consistency of standards and procedures across the province

- reporting to clinical and social care governance committees

    - make what they do clearly relevant to the problems faced by managers thereby encouraging managers to use the committees
    - match response timescales to the timescales in which managers have to work
    - ensure that the reporting systems are 'user-friendly'

- systems and administration

    - have well-designed, user-friendly recording, auditing and reporting systems
    - support a balance between standardised organisational procedures and the discretion practitioners need to individualise a service
    - establish good communications links (including email) within and between organisations
    - provide administrative support for managers and practitioners

- information

    - enable ready access to information and IT facilities
    - support access to material and opportunities to develop evidence-based practice

- workloads and time

    - cost and allocate the time needed to fulfil quality activities, taking account of the normal, unpredictable aspects of social work and social care and the level of staff resources
    - allocate time for learning and development

A second critical function is to provide the structures, conditions and resources under which learning from and about the governance systems is translated into revisions of the service, of practices and of the governance arrangements. *Using learning for review and revision is a fundamental element of the model.*

The third, reporting function concerns accountability and feedback to service users and carers, staff, agency partners, boards and external authorities. It represents both a feedback loop essential to the credibility and continued support of the system by its many participants and necessary formal and independent scrutiny of public services.

There was a unanimous commitment among staff in the Focus Groups to the goal of a quality service and to the arrangements necessary to support quality and accountability. Staff were also clear about the importance of a quality culture and of resources. These items will be taken up the next sections.

Fostering the quality culture

A quality culture was described by staff focus groups as fundamental in achieving the effective governance of a quality service. To summarise their views:

> *A quality culture in social care consists of a shared vision of governance and quality embodying social care values and a commitment to learning, participation, partnership, good communication, fostering trust and conveying a sense of value among staff.*

Staff focus groups gave the following examples as characteristic of a quality culture:

- Learning
    - an organisation open at every level to learning from all sources and events
    - a commitment to learning from mistakes without blame
    - a commitment to share learning between Trusts and other agencies and across the province

- Participation and Partnership
    - value placed on teamwork and cooperation
    - support for a culture of service partnership and collaboration between staff of different professions and agencies
    - participation of staff in the review and development of quality systems
    - participation of service users and carers and other professions and agencies in the review and development of quality systems

- Communication
    - commitment to communication between and across the different levels of the organisation, including front-line staff and senior management

- Trust and a sense of value
    - fairness in workloads
    - equality in opportunities for development and training
    - respect for and recognition of staff and care for their safety
    - corporate support for professional values.

Staff did not seek any dilution of their shared responsibility for a quality service and governance arrangements to support it. However, some suggested the appointment or designation of staff members with lead or champion role specifically for social care governance.

Securing and sustaining the human and other resources

The resources needed for a quality-led social care governance system include a governance model and the following :

- a plan and a feasible timescale for the introduction or further development of the governance model
- care service resources, including social care staff, in sufficient numbers and with the necessary knowledge and skills
- staff time to participate in the governance system as well as delivering the services whose quality the system is designed to support
- relevant technologies and information systems
- budgets to resource the above

Staff focus groups consistently registered the importance of resource factors in facilitating quality and maintaining staff morale. These factors included the quality and quantity of the workforce pool from which to recruit staff, recruitment budgets and staffing budgets. Other factors are administrative support, information technology including email and dictation equipment, and staff time to undertake stakeholder engagement, quality assurance and accountability activities and learning and development amid the priority demands of often unpredictable workload demands.

Service user and carers remarked on the importance of effective recruitment and selection to maintain service standards (Focus Group). These processes are part of the human resource management cycle of recruitment and selection, induction and orientation, development, retention and progression. Related to this is workforce planning based on using service plans and objectives to define staffing and skill requirements (Skills for Care 2004). Managers may be assisted in the latter task by using national occupational standards (NOS) to describe competencies needed for particular posts. NOS are available for social work, some post qualifying awards and for a range of health and social care National Vocational Qualifications (NVQs). Managers may also use NOS to gauge the skills held by staff to assist training needs analysis, in-house training design or evaluation and recruitment planning.

Staff focus groups identified social care *recruitment* as crucial and, in addition to budgetary factors described above, cited the challenges of:

- having an adequate pool in the population with the right knowledge and skills
- attracting staff into rural as well as urban areas

- attracting staff into all programmes of care
- competing with other, less onerous, employment.

The above challenges imply corporate strategic implications for long-term planning, review of labour markets and the social care workforce, as well as decisions on salaries, job conditions and other resources.

Staff focus groups gave examples of local action to enhance recruitment:

- offering practice learning sites to social work and care courses thereby both helping to increase the pool of qualified staff and aiming to attract students back as employees
- contributing to course teaching for the same reasons
- promoting the agency as a desirable place to work
- using an interactive website

Staff focus groups placed importance on *induction and orientation* in contributing to the foundations of a quality service. In their experience, the effectiveness of induction is enhanced when it:

- is part of a staged plan
- uses an induction pack
- uses induction standards
- is focused and job-relevant
- is participatory, with inductees sharing responsibility with managers and colleagues for defining induction and training needs and what is relevant
- provides contact with other, job-relevant professions
- explains the relevance of corporate and other general information

The Skills for Care common induction standards 2005 for care workers are ‘mapped’ to three other sets of standards: NVQs (which are based on national occupational standards), the NISCC code of practice for social care workers and the manager induction standards (SfC 2005).

There are defined arrangements for newly registered social workers in their first year of employment involving induction and supervision, work allocation, professional development and assessment (DHSSPS 2004). Development opportunities will also be needed to comply with re-registration requirements (NIPQETP 2005; NISCC 2005)

Staff focus groups identified a number of factors as supporting *staff retention,* some of which were discussed earlier. Strongly featured were:

- supervision
- training and continuous professional development
- a quality culture (defined above)
- good staff safety policies,
- strong infrastructural support

- quality systems (governance methods) that enhance professional practice and participation.

Staff retention along with morale and effectiveness are also likely to be affected by perceived stress levels, which surveys of the general workforce show to be the most common cause of absenteeism (Ramon 2005). In social care, stress comes predictably from the taxing nature of the work itself and also, significantly from the impact of managerial cultures that are perceived as poor at communication and consultation (Ramon 2005). Helping to sustain staff members means supporting them in handling the emotional impact of the work and in minimising organisationally-induced stress.

On the following pages, the figure, “Elements and activities of social care governance” given earlier, is now repeated for information and a figure (Fig. 24) added to suggest the dynamic nature of the cycle that the governance activities entail. The cycle is intended to suggest that learning and leading, managing and participating should interact constantly with engaging and assuring quality, and with one another.

The model of social care governance developed in this report is composed of

- the core elements (quality goals)
- the enabling elements (four elements and constituent activities)
- the continuous activity-and-learning cycle

References: Section 13

DHSSPS (2004) *The Assessed Year in Employment for New Social Work Graduates*, http://www.dhsspsni.gov.uk/publications/2004/AYE.pdf accessed 11/11/05.

NISCC (2005) *Registration – Introduction*, http://www.niscc.info/registration/default.htm accessed 11/11/05.

Northern Ireland Post Qualifying Education & Training Partnership (2005) *Development of NI Post Qualifying Framework Proposal for Professional Specification,* http://www.niscc.info/projects/pdf/PQ_Proposal.pdf accessed 11/11/05.

Ramon, S. (2005) “Responding to Perceived Stress in a Social Services Department: Applying a Participative Strategy”, *Research Policy and Planning*, 23, 1, pp.43-54.

Skills for Care (2005) *Common induction standards*, http://www.topssengland.net/view.asp?id=663 accessed 21/11/05.

(See below for Figs. 23 and 24.)

Fig. 23 (Fig. 13 repeated) Elements and activities of social care governance

Engaging with key stakeholders

- partnership with and involvement of service users and carers
- partnership with other professions and agencies
- communication and information to and from service users and carers
- communication and information within the agency and with other professions and agencies

Assuring quality and accountability

- risk assessment, risk management and ‘near miss’ analysis
- reporting of problems, latent issues and successes
- complaints and compliments management
- standards audit and case monitoring and review
- evidence-based practice
- staff supervision and performance management

Professional and Organisational Learning

- staff training and continuous professional development
- research including participation-based research
- learning from and applying the results and experience of quality assuring, partnership, information, training/development and research and reflections on the governance system

Leading, managing and participating

- developing, using, reporting on and revising the systems and structures for engaging with stakeholders, assuring quality, accountability and professional and organisational learning
- fostering the quality culture
- securing and sustaining the human and other resources

A Dynamic Social Care Governance Cycle

Fig. 24

review
& revise

Leading managing and participating

Engaging with stakeholders; assuring quality and accountability

Professional and organisational learning

review
& revise

Leading managing and participating

Engaging with stakeholders; assuring quality and accountability

Professional and organisational learning

Core goals of a quality service to users and carers:

- effective care outcomes
- effective care experience
- safe care practices
- involved users and carers

Part Four Implementing Social Care Governance: Roles, Leadership and Change

This Part will offer some principles and directions, using concepts from the model of social care governance developed in the main body of the report. A detailed formula for implementation is not offered for two over-riding reasons.

The first reason concerns the nature of the project and the field it has entered. The boundaries of the project did not permit comparative research and evaluation of the roles and responsibilities in governance systems. This does not mean that Northern Ireland lacks opportunities for such research; there is abundant scope for case studies and comparative analysis of the development of clinical and social care governance in Trusts, with their associated lead roles, committees and reporting structures (for example Foyle Trust 2005; Sperrin Lakeland Trust 2006).

A potential alternative source of a detailed blueprint for implementing social care governance, namely the literature, offers negligible coverage specifically on the subject. It is true that there are numerous materials on corporate and related governance, including strategic and board issues, but much of it is descriptive or prescriptive; comparative evaluation is hard to find. There is also an abundance on clinical governance but this, by definition, is focused on health systems and clinical issues. Furthermore, the clinical literature appears to be more concerned with either description and analysis or with compliance than with comparative evaluation. Hence, the project has not found a ready-made, detailed and tested blueprint structure of social care governance roles and responsibilities that can be applied in Trusts, or elsewhere.

A second reason for not attempting to offer a blueprint is that such a formula would imply that there is 'one best way' of organising and would limit the freedoms of flexibility, creativity and local discretion. These freedoms seem necessary locally in responding to two things: first, the changing environment and organisation of social care, including the restructuring under the Review of Public Administration (Secretary of State 2005) and, second, the development and testing of knowledge on how best to secure quality services through governance.

Principles and directions can certainly be indicated, however, and are given in two areas: roles and responsibilities (Section 14) and leadership, culture, change and the social care governance system (Section 15).

14. Social care governance roles and responsibilities in Trusts

The identification of social care governance roles and responsibilities in the following section seeks to use the underlying structure of ideas of the social care governance model. That structure is two-fold and given below in the core goals and four elements of the model:

The core goals of a quality service

- effective care outcomes
- effective care experience
- safe care practices
- involved service users and carers

Success in achieving these goals provides the ultimate test of effectiveness of all organisational roles in social care, including the governance-related roles that people perform. However, the four elements of the model (below) help more directly in thinking about a framework of governance roles and responsibilities.

The four elements of the social care governance model

- engaging with key stakeholders
- assuring quality and accountability
- professional and organisational learning
- leading, managing and participating

It is proposed that these four elements and their constituent activities (summarised in Figs. 13 and 23) provide an agenda at *all* organisational levels for the roles and responsibilities required in achieving a quality service. The precise nature of those roles and responsibilities will vary according to organisational level and function and to local structures and circumstances. The following figures (Fig. 25-27) attempt to illustrate the point by dividing organisational levels into three, *strategic*, *intermediate* and *operational* and indicating alongside, the kinds of roles and responsibilities that flow from the social care governance model.

Strategic roles are self-evidently about strategy. Intermediate level governance roles are primarily about development, review and support of governance and its systems. Operational level roles deliver the front-line implementation of governance systems.

It will be seen from the figures that the responsibilities repeat at different levels. One reason for this effect is that *governance is both a hierarchy and a* *network*. The *hierarchy* arises from the location of different kinds of responsibility at different levels. Hence, the Board and senior management have particular responsibilities in securing resources, setting the cultural climate, setting direction, securing participation and responding to issues raised by service users and carers and staff, in short for delivering the conditions needed by an effective social care governance system.

The *network,* on the other hand, is represented by the contributions that people at different levels make to similar functions. Thus, leadership and fostering a quality culture are functions that fall to people at *all* levels, not the property of one post or level.

Fig. 25 Strategic level governance roles and responsibilities

Level	**Roles/responsibilities**
Strategic (higher management and Boards)	***Strategically* lead, manage and participate in**: ▪ engagement with stakeholders/partners who include service users and carers and staff ▪ systems for assuring quality and accountability ▪ professional and organisational learning ▪ fostering the quality culture ▪ securing, sustaining and deploying human and other resources ▪ ‘whole system’ and service review, revision and development

Fig. 26 Intermediate level governance roles and responsibilities

Intermediate management and organisational ‘service roles’ (e.g. IT, R & D)	**Lead, manage and participate in *development*, *support* and *review* of**: ▪ engagement with stakeholders/partners who include service users and carers and staff ▪ quality assurance and accountability systems ▪ professional and organisational learning ▪ fostering the quality culture ▪ information and communications systems ▪ research and service development ▪ securing, sustaining and deploying human and other resources ▪ services, practice and governance

Fig. 27 Operational level governance roles and responsibilities

Level	Roles/responsibilities
Operational management and practitioners	**Lead, manage and participate in the *front-line implementation* of:** ▪ engagement with stakeholders/partners ▪ assuring quality and accountability ▪ professional and organisational learning ▪ fostering the quality culture ▪ securing, sustaining and deploying human and other resources ▪ review of services, practices and governance

It is important to be reminded that the roles and responsibilities described in the three figures above do not represent the core business of the Trust and its staff. That core business concerns the resourcing, organisation and delivery of the service itself, the quality service. The figures describe an enabling infrastructure of governance activities that facilitate, examine, verify, review, report on and endeavour to improve the quality of that social care service.

15. Leadership, culture, change and the social care governance system

Section 3 introduced leadership as a significant component of the proposed social care governance model. The discussion referred to leadership as a function that could be taken by a variety of people in the governance system and implied that leadership is not solely a property of particular roles, such as Director or chair of a Board or committee. This perspective did not mean, however, that the power, authority and opportunities for leadership are distributed equally in an organisation. On the contrary, senior people are uniquely placed in the effect they can have in setting the direction and pace of change, in determining the model and methods of governance and in shaping the governance culture. These effects in turn critically set the direction and scope of roles and opportunities for others to lead and contribute across the organisation.

This Section will draw on particular resources to suggest principles and directions for organisational leaders in introducing or developing social care governance systems. The resources are recent research on leadership of change in social care, the project focus groups and the experience of authorities consulted during project research. To begin, it is important to set the context.

> First, modern health and social care and their environments are *complex* systems in which multiple parts interact and expertise is diffuse, being held in many locations and roles.
>
> Second, social care governance requires development and *change* arising both in the introduction or elaboration of governance models and in the alterations of services and practice that the governance system is designed to bring.

It is increasingly argued that the expertise in complex systems cannot be connected and realised by decree or structures alone. These goals require the initiative, cooperation and commitment of those involved. It is recognised, similarly, that *change in complex human systems requires collaboration and participation* (Barnes 2004). Work on methods of collaborative change has found that such change is more likely when it builds on strengths, that is, on what people value and their experience of what works (Cooperrider and Whitney 1999; Whitney and Trosten-Bloom 2003).

These ideas underpinned the focus groups held for this project and yielded a rich set of contributions, which are cited in the earlier text. The focus group process listened to those involved and sought to use participants' values, concerns and positive experience to inform the model of social care governance. The approach mirrors the principles of *cultural change in organisations* that researchers on innovation, leadership and restructuring in public sector services have found to be so fundamental to success (Lownsborough and O'Leary 2005).

The research shows the importance of leadership that encourages participation, understands the significance of the values and priorities of staff and seeks to foster their commitment to change through involvement. The research cautions against over-reliance on inspection and accountability frameworks. These methods have a useful function but can centralise change initiatives and induce routine compliance (Power 2004) at the expense of the deeper involvement needed for creative engagement and change of role and relationships: in short, at the expense of a culture of commitment and participation. The researchers argue that attention to culture is especially relevant in services that bring together different professionals and different providers and where values and priorities have to be reconciled if those involved are going to work in a coherent way.

The themes of culture and leadership are brought together strongly in the policy guidance published by the DHSSPS in 2003:

> "Developing the right culture is perhaps one of the biggest challenges in establishing clinical and social care governance processes. It will take dynamic leadership, time and commitment from all levels of the organisation (DHSSPS 2003 para 14)".

The guidance describes the characteristics that such leadership requires, namely:

- "**inclusivity:** ensuring that all staff in the organisation are involved and kept fully informed about the purpose and progress of the clinical and social care governance programme;
- **commitment from the top:** reporting and having access to the Chief Executive and the board, particularly when problems need to be resolved or barriers to progress have been identified;
- **good external relationships:** forging strong open working partnerships with users, local communities, health and social care organisations and other agencies in the locality;
- **good internal relationships:** forging ownership of clinical and social care governance by the employees of an organisation;
- **continuing focus:** keeping the arrangements on course and not being deflected from the goals that the organisation has set itself;
- **accounting for progress:** being able, on request, to provide a comprehensive overview of progress with the clinical and social care governance arrangements programme throughout the organisation; and
- **communication:** with all staff in the organisation and with external partners, users and local communities on a regular basis (DHSSPS 2003 para 24)".

Sources gathered for this report suggest ways of taking forward some of these leadership imperatives and are especially relevant where the process involves significant development and change of structures and practices. Chief sources (Fig. 28) are the findings of Lownsborough and O'Leary in their Demos study of organisational reform in social care together with the perspectives of project focus groups and discussion with others consulted for this project (Fig. 29) (Whittington, B. 2005). Suggestions on the process are given below and followed by suggestions on the characteristics that should underpin the governance model adopted. The focus is primarily although not exclusively on change affecting parties within the organisation.

Fig. 28 Suggestions for leaders on the change process

Leaders should…	**Explanation**
Create clear frameworks at the start of implementation	
Provide opportunities for staff and service users and carers to feed in to the process of shaping the model before it is concrete.	This does not mean complete agreement on everything before decisions can be made. Leaders in the Lownsborough and O'Leary study "were able to make progress without seeking consensus from all their workers and users, having earned their trust through the process of seeking their views and taking them seriously" (2005 p.36.)
Use new formal structures as practical signals but not as instruments of change themselves	Structures can send clear signals about the direction of change and highlight issues or problems but should not substitute for the relational aspects which, as stated earlier, are the dynamic source of governance systems, shaping how they work and delivering ideas for improvement and change
Pace change at the appropriate rate, understanding that people engage at different speeds	People can be overwhelmed when confronted with too much change at once
Respond constructively to people who are reluctant to alter working practices instantaneously. Give legitimate opportunities for reservations to be expressed and for fears to be assuaged. Be willing to have difficult conversations about ways of achieving change	Sometimes reluctance is connected directly to people's professionalism which prompts two sets of concerns: first, will the change improve outcomes for service users and carers?; second, will the process and resulting changes threaten their ability to maintain services? Responding to people's fears and resistance rather than criticising them can help change to be accepted more quickly, and may add improvements to the system
Look for the best prospects of a few quick and encouraging 'small wins'	Early success stories can boost morale and offset frustrations in other areas
Identify champions of change early on and prepare them with good understanding of objectives and methods and with consultative skills Pilot approaches to test and demonstrate workability and share the results across the organisation Invite small groups from different parts of the organisation or professions to volunteer to develop or test methods Make strategies as open, transparent and inclusive as possible	Staff who see evidence of methods that work and who have among them trusted and enthusiastic colleagues who have helped to develop them, can be enthused themselves

The culture of social care workers and social workers, on the one hand, and of the wider organisations in which they are employed, on the other, are not identical. Furthermore, it is by no means always the culture of the professionals that most needs to change. Organisational cultures include a management culture, which may need to change too. In weighing the consequences of different cultures within the organisation, one of the key roles of organisational leaders is to ensure that the model of social care governance being introduced is as compatible as possible with the best characteristics of professional practice that the organisation wishes to sustain. This seems a good way of enlisting the commitment of professional staff and support of service users and carers. Suggestions derived from the project are given below:

Fig. 29 Suggestions for leaders on the social care governance model

Leaders should ensure that the governance model is …	**Elaboration**
Realistic	The definition of quality cannot be utopian and must relate realistically to levels of resourcing
Meaningful	The aims, methods and definitions of quality should be recognised by professionals as relevant to their practice and by service users and carers as relevant to their needs and experience
Professionally-aligned	Governance activities need to align as closely as possible with professional activities in delivering services and not reduce contact with service users and carers
Focused and efficient	Takes care to identify those aspects that need to be quality assured and reported on in detail and distinguishes the from those that do not
Provides feedback	Builds in feedback loops to demonstrate positive outcomes and explain where action cannot be taken immediately to resolve issues and why
Asset-focused as well as deficit-focused	Looks for innovative work and what works well, seeking to build on them, as well as understanding what goes wrong
Risk-aware not risk-averse	Recognises that the duty is responsible risk assessment and management, not elimination
Learning-oriented not blame-oriented	Encourages learning and seeks to avoid blame
Sustains credibility and involvement	Gives staff and service users and carers central roles in evaluating and improving the model
Demonstrably supports quality objectives	Uses relevance to the achievement of quality objectives as the test of each method and activity in the model

Key policy imperatives

The sets of suggestions in Figures 27 and 28 do not complete the picture. In implementing governance responsibilities, Trust Directors and Board have been given particular points of reference. One such reference is the *Controls Assurance Standard for HPSS on Governance* (DHSSPS 2005). The standard is strategically-pitched and addresses what would broadly be recognised as corporate governance. It does not stand directly as a manifesto for social care governance, yet any model of social care governance in Northern Ireland needs to show how it relates to the standard. The quality-focused model developed for this report does not aim to replicate the standard and its higher-level governance aims. However, it aligns closely with the standard's injunctions on accountability and reporting, risk management, monitoring, learning and improving, communication and consultation, governance capability and the review and revision of systems. Social care governance built around the model should assist a Trust Board in its responsibility to "demonstrate that it has done its reasonable best to achieve its objectives and outcomes" (DHSSPS 2005).

The DHSSPS governance standard also cites the expectation that HPSS bodies should properly address the 'statutory duty of quality'. In doing this, Trusts will refer to *The Quality Standards for Health and Social Care.* The duty of quality and the *Quality Standards* were also primary points of reference in the development of the model of social care governance for this report. Again, the model aligns with the duties of Trusts.

Outline of a social care governance system

This report has not volunteered an absolute definition of social care governance because it is no single thing. The report has concentrated particularly on social care governance as a *model*, defined by:

- quality goals
- enabling elements (four elements and constituent activities)
- the continuous activity-and-learning cycle

But social care governance is not only a model. It is a set of *aspirations* which are shared with many other models and levels of governance: aspirations to learn from things that have gone wrong, and gone right, in order to improve services; to fulfil accountability to internal and external stakeholders; and to make involvement mainstream. Realising these aspirations depends on harnessing a multiplicity of *components* and takes the analysis beyond any single model of social care governance towards a *social care governance system*.

The research for the report has identified seven such components and all have been discussed at different points. The components are summarised below and in Figure 30 and provide the conclusion to this report.

The components of a social care governance *system* are:

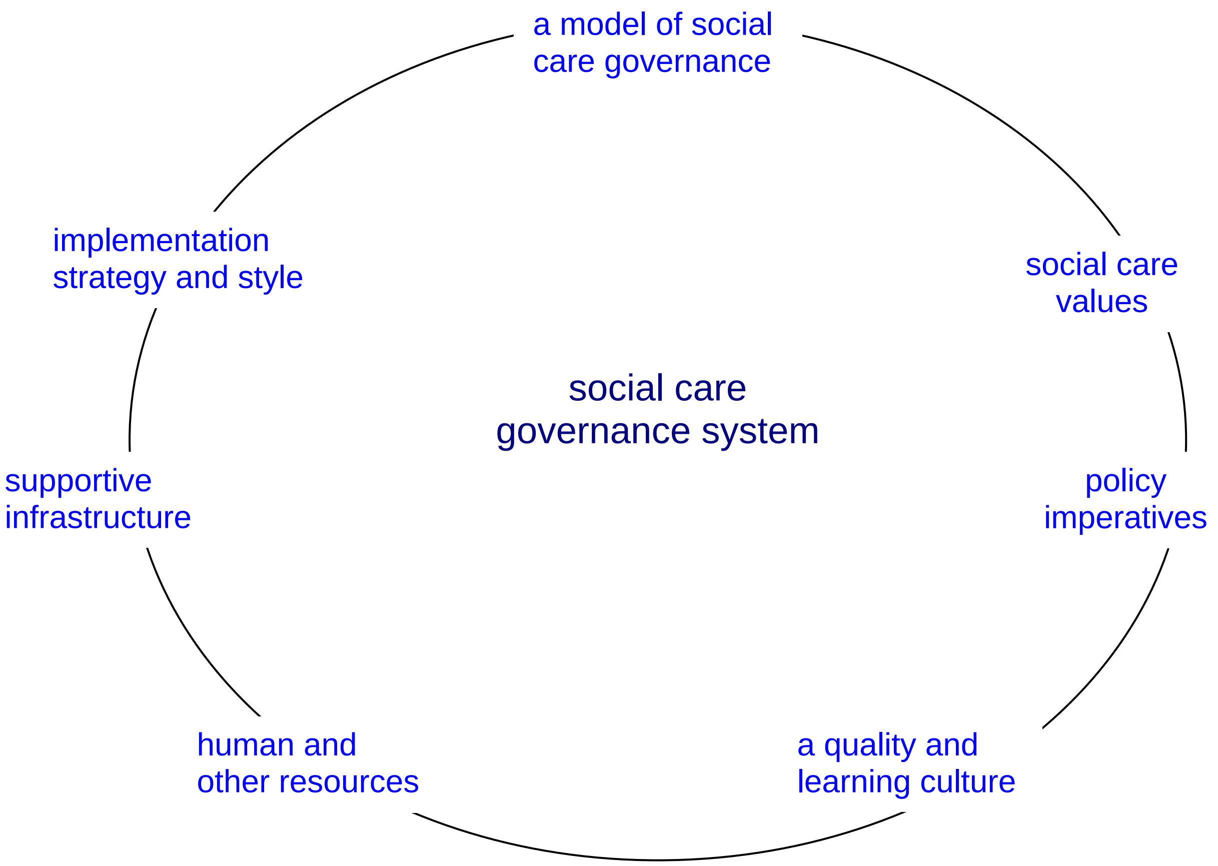
- a model of social care governance
- social care values
- the imperatives of government and local policy
- a culture of quality and learning
- human and other resources
- a supportive infrastructure
- a strategy and style for implementation

One of the components is the model of social care governance developed here. The model addresses and seeks to 'service' a number of the other components but, as a model of a way of doing things, a set of potential formal structures and sets of relationships, it needs activation.

Similarly, the entire set of components depend on a kind of activation to transform the set into a social care governance *system*. That is, the individual components must become *practically interconnected and this must be done in a way that makes the connections visible to all involved*. This task implies particular responsibilities for organisational leaders and for policy-makers at central, regional and local levels, but it also implicates participants system-wide, that is, within organisations and beyond their increasingly fluid boundaries.

(Fig. 30 appears below.)

Fig. 30 Components of a social care governance system



References: Part Four (including Sections 14 and 15)

Barnes, J. (2004) “Waving or Drowning? Tackling Performance in Local Authority Services”, *Research Policy and Planning,* 22, 3, pp.61-69.

Copperrider, D. and Whitney, D. (1999) *Collaborating for Change: Appreciative Inquiry* Francisco: Berret-Koehler.

DHSSPS (2003), *Governance in the HPSS: Clinical and Social Care Governance - Follow up to circular HSS (PPM) 10/2002*. http://66.102.9.104/search?q=cache:btmD2tn9fTAJ:www.dhsspsni.gov.uk/hss/governance/documents/circular_hss_(ppm)_10_2002.doc+HSS+(PPM)+10/2002&hl=en accessed 05/08/05.

DHSSPS (2005b) *Controls Assurance Standard HPSS – Governance* http://www.dhsspsni.gov.uk/hss/governance/documents/governance_05.pdf accessed 03/08/05.

Foyle Health and Social Services Trust (2005) “Clinical and Social Care Governance Proposals”, Trust document.

Lownsborough, H. and O'Leary, D. (2005) *The Leadership Imperative: Reforming children's services from the ground up*, http://www.demos.co.uk/catalogue/leadershipimperative accessed 07/01/06. (Ref ID: 290)

Power, M. (2004) *The Risk Management of Everything*, www.demos.co.uk/riskmanagementofeverything_pdf_media_public.aspx, accessed 07/01/06.

Secretary of State for Northern Ireland (2005) *Statement by the Secretary of State for Northern Ireland on the Outcome of the Review of Public Administration*, http://www.rpani.gov.uk/announce.pdf accessed 08/12/05.

Sperrin Lakeland Health and Social Care Trust (2006) http://www.sperrin-lakeland.org/information/trust_board_minutes.php accessed 10/04/06.

Whitney, D. and Trosten-Bloom, A. (2003) *The Power of Appreciative Inquiry* San Francisco: Berret-Koehler.

Whittington, B. (2005) “Governance Implications of Quality Assurance in HE”, notes on a consultation.

Dr Colin Whittington
11th April 2006

Appendix 1

Focus Groups

1. Focus groups with service users, carers and supporters

The purpose of the groups was gain views on the following:

- what needs to happen to ensure that people have the involvement they want in the care services they are receiving?
- what needs to happen to enable service users and carers to have the say they want on
    - how a service is working
    - the planning or improvement of a service

In each case, it was hoped, without glossing over difficulties, to learn what ‘works well’.

Participation

Nominations of participants were received with the assistance of HSS Councils. Participants had experience of services for adults, including services for mental health, older people and disabilities. Experience of family and child care services was sought unsuccessfully.

service users	carers	support workers
10	8	3

2. Focus groups with social workers, social care workers and first-line and middle managers from HSS Trusts

The purpose of the groups was to talk about the kinds of ‘arrangements’ (structures, practices and procedures) used in HPSS agencies to encourage and facilitate a quality service and to monitor, review and improve that service.

Again, problems were not glossed but it was hoped to learn what has worked well or what arrangements participants would particularly like to see built-upon.

Participation

Nominations of participants were received with the assistance of Directors of Social Work in Trusts and all but one Trust were able to send nominees. Participants had experience of the full range of services.

front-line staff	first-line and middle managers
18	15

Note: Lorraine Simmons, NICSCGST has also met periodically with Directors to provide briefings and gain views on the project.

Appendix 2

Bibliography of additional of works consulted and not cited in section-end references in the report

ADSS (Association of Directors of Social Services) (2005) *ADSS response to the consultation on Guidance on the Role of the Director of Adult Social Services*. http://www.adss.org.uk/publications/consresp/2005/independdass.shtml, accessed 24/10/2005.

Ajetunmobi, O.(2002) *Making Sense of Critical Appraisal*, London: Hodder Arnold.

Alaszewski, Andy (2003) “Risk, clinical governance and best value: restoring confidence in health and social care” in *Clinical Governance and Best Value* by Sharon Pickering and Jeanette Thompson (eds) London: Churchill Livingstone pp. 171-182.

Anderson, Y. (2005) “The Partnership Facilitation Programme”, *Mental Health Review*, 10, 3, pp.25-30.

Appleby, J. *Independent Review of Health and Social Care Services in Northern Ireland,* http://www.dhsspsni.gov.uk/publications/2005/appleby/appleby-report.pdf , accessed 8/12/2005.

Attwood, M. (2004) *Leading change: a guide to whole systems working*, Bristol: Policy Press.

Barton, C. (2003) "Allies and Enemies: The Service User as Care Co-ordinator," in *Collaboration in Social Work Practice*, J. Weinstein, C. Whittington, & T. Leiba, eds., London: Jessica Kingsley, pp.103-120.

British Council (2004) *Governance in Northern Ireland,* http://www.britishcouncil.org/northernireland-society-governance.htm , accessed 25/07/2005.

Buetow, S. A. and Roland, M. (1999) “Clinical governance: bridging the gap between managerial and clinical approaches to quality of care”, *Quality in Health Care,* 8, pp.184-190.

Bunting, A. (2005) “Performance Coordinating Group”, *SSRG Newsletter,* December, pp.10-11.

Burchett, Karen (2005) “Table of Standards for Better Health”, Queen Mary Hospital Sidcup.

Campbell, S. M., Sheaff, R., Sibbald, B., Marshall, M. N., Pickard, S., Gask, L., Halliwell, S., Rogers, A., & Roland, M. O. (2002) “Implementing clinical governance in English primary care groups/trusts: reconciling quality improvement and quality assurance", *Quality and Safety in Health Care,* 11, pp.9-14.

Carers UK (2005) *Back me up*, http://www.carersuk.org/Policyandpractice/Research/BackMeUp.pdf accessed 06/12/05.

Carers UK (2003) *Missed opportunities: the impact of new rights for carers*, http://www.carersuk.org/Policyandpractice/Research/MissOpsExecSummary.pdf accessed 06/12/05.

Caress, A. L. and Scott, L. (2003) "Shared governance and shared leadership: meeting the challenges of implementation", *Journal of Nursing Management*, 13, 2, pp. 4-12.

Carmichael, P. (2002) *Multi-level Governance: Briefing Paper for the Review of Public Administration*, http://www.rpani.gov.uk/multilevel/ accessed 26/09/05.

CCNAP (2001) "'Asking the Experts': A guide to involving people in shaping health and social care services", http://www.ccnap.org.uk/layout.htm accessed 26/10/05.

CGST (Clinical Governance Support Team) (2005) *Clinical Governance Defined*, http://www.cgsupport.nhs.uk/About_CGST/Clinical_Governance_defined.asp accessed 08/08/05.

CGST *Clinical Governance*, http://www.cgsupport.nhs.uk/ accessed 27/07/05.

Chief Inspector, SSI (2005) "Good Practice in Consent - social work students", . SSINI.

CGST (2004) *Board Assurance Prompts for Good Governance*, http://www.cgsupport.nhs.uk/downloads/Board_Assurance_Prompts.pdf, accessed 06/01/06.

Commission for Healthcare Audit and Inspection (2005) *Clinical governance and integrated governance*, London: Healthcare Commission.

Commission for Social Care Inspection (2005) *Race Equality Scheme*, London: CSCI.

Comptroller and Auditor General (2003) *Achieving Improvements through Clinical Governance: A Progress Report on Implementation by NHS Trusts*, http://www.nao.org.uk/publications/nao_reports/02-03/02031055.pdf accessed 03/08/05.

Cornforth, C. (2003), *The Governance of Public and Non-Profit Organisations* Abingdon: Routledge.

Corry, D. et al. *Joining up Local Democracy: governance systems for new localism. New Local Government Network*, London: New Local Government Network.

Craig, G. and Manthorpe, J. (2004) *Unfinished business: local government reorganisation and social services*, Bristol: Policy Press.

CSCGST (2005) *Clinical and Social Care Governance Arrangements Review/Initial baseline* assessment. http://www.dhsspsni.gov.uk/hss/governance/documents/CSCG_proforma.doc accessed 24/08/05.

Daly, M. 2003, "Governance and social policy", *Journal of Social Policy*, 32, 1, pp. 113-128.

Davies, C., Finlay, L., and Bullman, A. E. (1999) *Changing practice in health and social care,* London: Sage.

Dearden, C. and Becker, S. (2004) *Young Carers in the UK*, http://www.carersuk.org/Policyandpractice/Research/YoungcarersReport2004.pdf accessed 06/12/05.

Deighan, M. and Moore, R. (2004) *The development of integrated governance. Debate. No.3*, The NHS Confederation.

Department of Health (2000), *National Service Framework for Coronary Heart Disease : Executive Summary* http://www.dh.gov.uk/assetRoot/04/05/75/25/04057525.pdf. accessed 08/03/06

Department of Health (2003) *Corporate Governance Framework Manual for Primary Care Trusts sixth edition*, http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareTrusts/PrimaryCareTrustsArticle/fs/en?CONTENT_ID=4000579&chk=NAzQg6 accessed 03/08/05.

Department of Health (2000) *A Quality Strategy for Social Care*, London: DoH.

Department of Health (2003) *Building the Assurance Framework: A Practical Guide for NHS Boards,* http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4093992&chk=HDppmF accessed 03/08/05.

Department of Health (2005) *Governance*, http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Governance/fs/en accessed 24/10/05.

Department of Health (2005) *NHS Audit Committee Handbook* Gateway Reference 5706. http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolic yAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4121924&chk=Anpk3z accessed 13/12/05.

Department of Health (2005) *Providing Assurance on Clinical Governance: A Practical Guide*, http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108408&chk=Kkoe7j accessed 24/10/05.

Department of Health (2006) *Social Care Information Governance*. http://www.dh.gov.uk/PolicyAndGuidance/InformationPolicy/InformationForSocialCare/CaldicottArticle/fs/en?CONTENT_ID=4075306&chk=dvqjYH accessed 23/01/06.

Department of Health (2004) *Standards for Better Health*. London: Department of Health.

DfES (2006) *Children's Trust Governance and Accountability: Questions and Answers,* http://www.everychildmatters.gov.uk/_files/76D9C3632467027A7DC264DA94335F85.pdf accessed 06/01/06.

DfES (2005) *The Information Sharing Index,* http://www.dfes.gov.uk/ISA/ accessed 06/01/06.

DFPNI (2004) *Press release: Independent Health Review,* http://www.dfpni.gov.uk/ihr/pdfs/Final_IHRPressRelease.pdf accessed 13/12/05.

Department of Health Social Services and Public Safety (1998) *Fit for the future* Belfast: DHSSPS.

DHSSPS Service Improvement Unit. Sharing improvements across the health service (Northern Ireland) http://www.nics.gov.uk/press/hss/050921a-hss.htm accessed 08/12/05.

DHSSPS (2002). *Clinical and Social Care Governance: Departmental Guidance* (July) (HSSPPM 10/2002), Belfast: DHSSPSNI.

DHSSPS (2005) . “Governance in Child Care: view from the Department: Roles and Responsibilities of the Department, Boards and Trusts - speaking notes”, Belfast: DHSSPS.

DHSSPS (2005) *Governance in HPSS*, http://www.dhsspsni.gov.uk/hss/governance/guidance.asp. accessed 01/11/05.

DHSSPS & NISCC (2003) *Northern Ireland Framework Specification for the Degree in Social Work*, http://www.niscc.info/careers/pdf/SW_framework_spec_0303.pdf accessed 08/12/05.

DHSSPS (1999) *Fit for the Future - A New Approach. The Government's Proposals for the Future of the Health and Personal Social Services in Northern Ireland*, Belfast: DHSSPSNI.

DHSSPS (2003) “Pilot review of clinical and social care governance arrangements”, Press Release accessed 30/11/05. http://www.nics.gov.uk/press/hss/030903a-hss.htm accessed 30/11/05.

DHSSPS (2004) *Caring For People Beyond Tomorrow. A Strategic Framework for the Development of Primary Health and Social Care for Individuals, Families and Communities in Northern Ireland,* Belfast: DHSSPSNI.

DHSSPS (2004) *A Healthier Future: A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2025 Consultation*, . http://www.childpolicy.org.uk/dir/index.cfm?ccs=2149&cs=13402 accessed 08/12/05.

DHSSPS (2005) *Care Standards,* http://www.dhsspsni.gov.uk/hss/care_standards/index.asp accessed 10/01/06.

DHSSPS (2005) Controls Assurance Standard HPSS - Financial Management. http://www.dhsspsni.gov.uk/hss/governance/documents/financial_05.doc accessed 13/12/05.

DHSSPS (2005). Controls Assurance Standard HPSS - Risk. http://www.dhsspsni.gov.uk/hss/governance/documents/risk_05.pdf accessed 13/12/05.

DHSSPS (2002) *Developing a Regional Strategy for the Health and Personal Social Services 2002-2022* http://www.dhsspsni.gov.uk/hss/reg_strategy/cons_doc.asp accessed 27/07/05.

DHSSPS (2005) *Summary of Best Practice Best Care*, http://www.dhsspsni.gov.uk/publications/ahp-docs/Best_Practice_Best_Care.pdf accessed 29/07/05.

Director of Family and Elderly Care DHSSPS (2005) “Development of Single Assessment Tool for Assessing Older People's Needs for Health and Social Care”, Belfast: DHSSPSNI.

Douek, S. (2003) "Collaboration or Confusion? The Carer's Perspective," in *Collaboration in Social Work Practice*, J. Weinstein, C. Whittington, & T. Leiba, eds., London: Jessica Kingsley, pp. 121-136.

Eastern Health and Social Services Board (2005) *Mental health strategy for adults aged 18-65. Analysis of policy, guidance and drivers for change at regional and area board level. Product Three.* EHSSB.

Employers Organisation for Local Government (2005) *National Occupational Standards*, http://www.lg-employers.gov.uk/skills/nos/ accessed 08/12/05.

Equality Commission for Northern Ireland (2005) *Statutory Duty*, http://www.equalityni.org/ftp/Stat1.html accessed 03/08/05.

Farrell, C. M. (2005) "Governance in the UK public sector: the involvement of the governing board", *Public Administration*, 83, 1, pp. 89-110.

Field, R. *Clinical governance*, http://www.cgsupport.nhs.uk/Resources/Leading_the_way/Rosemary_Field.asp accessed 10/10/05.

Ford, D. and Wakeling, D. (2004) "You've been CHI'd: clinical governance and quality in the post-modernisation (post-CHI) NHS", *Mental Health Review*, 9, 3, pp. 6-12.

Foyle Health and Social Services Trust 2005, *Clinical and Social Care Governance Committee*.

Freeman, T. & Walshe, K. (2004) “Achieving progress through clinical governance? A national study of health care managers” *Quality and Safety in Health Care* 13, 335-343.

Frew, L. (2002) “Roles and Responsibilities of Directors for the Care and Protection of Children”, letter CC3/p2. DHSSPSNI.

Glasby, J. and Peck, E. (2004) *Integrated working and governance: a discussion paper,* http://www.integratedcarenetwork.gov.uk/inthelp_theme.php?id=4 accessed 08/08/05.

Glasby, J. and Peck, E. (2005) “We have to stop meeting like this: the governance of children and young people's services. A discussion paper”. HSMC Birmingham University, http://www.hsmc.bham.ac.uk/news/JG-discussion%20paperDec05.pdf accessed 06/01/06.

Glendinning, C., Powell, M., and Rummery, K. (eds) (2002), *Partnerships, New Labour and the Governance of Welfare,* Bristol: Policy Press.

Goss, S. 2001, *Making Local Governance Work*, Houndmills Basingstoke: Palgrave.

Halligan, A. (2003) “The Implementation of Clinical Governance”, *Health Director* March/April, pp. 14-15.

Halligan, A. and Donaldson, L. (2001) “Implementing clinical governance: turning vision into reality”. *BMJ* 322, June, 1413-1417.

Hambleton, R. (2004), "Leading localities in a partnership era", *Local Governance*, 30, 1, pp. 4-13.

HARTLEY, J. (2004) "Innovation in governance and public services: past and present", *Public Money and Management*, 25, 1, pp. 27-34.

Healthcare Commission (2004) *Manual of clinical governance review/inspection practices Edition 4*, http://www.healthcarecommission.org.uk/assetRoot/04/00/85/15/04008515.pdf accessed 03/08/05.

Healthcare Commission (2005) *Trust Clinical Governance Arrangements [detailed questions] MH Trusts*, http://www.healthcarecommission.org.uk/assetRoot/04/00/17/95/04001795.pdf accessed 03/08/05.

HM Treasury (2005) *Corporate governance in central government departments: Code of good practice*, accessed 14/01/06.

Hudson, B., Dearey, M., & Glendinning, C. (2005) *A New Vision for Adult Social Care: Scoping service users' views,* York: Social Policy Research Unit.

Huxham, C. (2000) "The Challenge of Collaborative Governance. Public Management", 2, 3, pp.337-357.

Integrated Care Network (ICN) "Integration and Partnership Working: What's working, not working and how can it be encouraged", http://www.integratedcarenetwork.gov.uk/docs/resources/427/251.doc accessed 01/02/06.

Independent Commission for Good Governance in the Public Services (2005) *The Good Governance Standard for Public Services*. OPM and CIPFA http://www.opm.co.uk/ICGGPS/download_upload/Standard.pdf accessed 24/10/05.

Integrated Care Network (2005) "Advisory Note 2: Corporate Governance and Integrated Working" http://www.integratedcarenetwork.gov.uk/docs/resources/46/21.doc accessed 06/07/05.

James, A., Worrall, A., and Kendall, T. (eds) (2005) *Clinical Governance in Mental Health and Learning Disability Services: A Practical Guide,* London: Gaskell (Royal College of Psychiatrists).

JRF (Joseph Rowntree Foundation) (2004), *Sustainable development in Wales: understanding effective governance*, York: JRF.

JRF (2002) "Confusion over governance holds back community and small voluntary groups" http://www.jrf.org.uk/pressroom/releases/231002.asp accessed 05/08/05.

JRF (2003) "Governance: overview of the governance and public services programme" . http://www.jrf.org.uk/funding/research/prioritiesandcalls/priorities/governance.asp accessed 05/08/05.

Knox, C. (2002) *Partnerships: Briefing Paper* http://www.rpani.gov.uk/partnerships/index.htm accessed 02/08/05.

Local Government Association (nd) *Care Trusts: governance issues for local authority elected members*. http://www.integratedcarenetwork.gov.uk/docs/resources/217/80.pdf accessed 24/10/05.

Newton, J. 2001, *Modernising governance. New Labour, policy and governance* London: Sage.

NHS Appointments Commission (2003) *Governing the NHS. A guide for NHS Boards*, http://www.dh.gov.uk/assetRoot/04/08/26/37/04082637.pdf accessed 05/08/05.

NHS Executive (1999) *Governance in the new NHS: Controls Assurance Statements 1999/2000. Risk management and organisational controls* HSC 1999/123. http://www.dh.gov.uk/assetRoot/04/01/19/97/04011997.pdf accessed 09/01/06.

NHS Health and Social Care Information Centre (2006) *Clinical Governance Information Checklist* http://www.icservices.nhs.uk/clinicalgovernance/pages/cg_request.asp accessed 06/01/06.

NHS Quality Improvement Scotland (2003) *Generic Clinical Governance Standards National Overview*. http://www.nhshealthquality.org/nhsqis/files/genericnatoverview.pdf accessed o3.08/05.

NICCY (2005) *Northern Ireland Commissioner for Children and Young People* http://www.niccy.org/ accessed 21/12/05.

NICSCGT (2005) . “An Integrated Approach to Clinical and Social Care Governance” PowerPoint presentation, DHSSPS.

Northern Ireland Office (2005) PBNI Professional Staff Remuneration Review Report. http://www.nio.gov.uk/pbni_professional_staff_remuneration_review_report_may_2005.pdf accessed 21/11/05.

NISCC (Northern Ireland Social Care Council) (2005) *Continuing Professional Development for Social Work* http://www.niscc.info/careers/develop/default.htm accessed 07/12/05.

NISCC (2003) *Curriculum Guidance for the Degree in Social Work: The Northern Ireland Context,* http://www.niscc.info/careers/qualify/curriculum_guidance.htm accessed 07/12/05.

NISCC (2002) *Equality Scheme: drawn up in accordance with Section 75 and Schedule 9 of the Northern Ireland Act 1998* http://www.niscc.info/about/pdf/Revised_Equality_Scheme.pdf accessed 05/01/06.

NISCC (2004) *Induction and foundation standards for social care workers*, http://www.niscc.info/projects/induct_stands.htm accessed 07/12/05.

NISCC (2005) *Investing in Practice Learning, Investing in the Future Workforce: NISCC Standards for Practice Learning Providers – Consultation*, http://www.niscc.info/projects/induct_stands.htm accessed 29/07/05.

North and West Belfast HSS Trust (2005) *Risk Management Induction & Awareness: What You Need to Know. DHSSPS Online governance learning, http://www.dhsspsni.gov.uk/hss/governance/learning.asp* accessed 28/07/05.

Northern HSSB (2004) *Clinical and Social Care Governance: Annual Report,* http://www.nhssb.n-i.nhs.uk/cscg.php accessed 03/08/05.

Northumberland Tyne & Wear Health Authority (2005) *Audit Tool for Governance Issues and the Care of Vulnerable People*, A Users' Guide Version 4, http://kc.nimhe.org.uk/upload/Rowan%20Ward%20Audit%20Tool%20version%204%20-%201st%20April%202005.doc accessed 06/10/05.

OCPANI (2005) *The Office of the Commissioner for Public Appointments for Northern Ireland* http://www.ocpani.gov.uk/bodies.htm accessed 08/12/05.

O'Halloran, C., Hean, S., Humphris, D., & MacLeod-Clark, J. (2005) *Developing Common Learning: the New Generation Project undergraduate curriculum model*. Health Care Innovation Unit, University of Southampton, . http://eprints.soton.ac.uk/14066/ accessed 12/10/05.

O'Neill, M. & Campbell, J. (2005) *Curriculum Guidance for the Degree in Social Work Community Social Work and Community Development,* http://www.niscc.info/careers/pdf/Community_dev_curr_guide.pdf accessed 08/12/05.

Owen, J. & COOKE, J. (2004), "Developing research capacity and collaboration in primary care and social care: is there enough common ground? *Qualitative Social Work*, 3, 4, pp. 389-410.

Peck, E., 6, P., Glasby, J., & Skelcher, C. 2004, "Governance and partnerships
Journal of Integrated Care, 12, 4, pp. 3-8.

Peck, E., Gulliver, P., & Towell, D. (2002) "The Governance of Partnerships between Health and Social Services: the experience of Somerset", *Health and Social Care in the Community* 10, 5, pp. 331-339.

Peck, E., Towell, D., & Gulliver, P. (2001) "The Meanings of Culture in Health and Social Care: a study of the combined Trust in Somerset", *Journal of Interprofessional Care* 15, 4, pp. 319-327.

Pickering, Sharon and Thompson, Jeanette (2003) *Clinical Governance and Best Value*, London: Churchill Livingstone.

Pickup, S. (2004) "Partnership and governance: the Hertfordshire experience *Journal of Integrated Care*, 12, 2, pp. 14-19.

QAA (Quality Assurance Agency) (2004) *A draft statement of Common Purpose for Subject Benchmarks for the Health and Social Care Professions: Consultation*. http://www.qaa.ac.uk/academicinfrastructure/benchmark/health/draft/common_purpose.asp accessed 03/08/05.

RCGP (2000) *Purpose of National Service Frameworks*, http://www.rcgp.org.uk/clinspec/workshops/rhetoric/rhetoric4.asp accessed 27/07/05.

RCGPNI (2004) *Overview of clinical and social care governance report*, http://www.rcgp-ni.org.uk/ni/CSCG%20Report.htm accessed 05/08/05.

Richards, S. (2003) *Leadership - an exploration of issues relating to leadership in the public domain. Paper for the Northern Ireland Review of Public Administration* http://www.rpani.gov.uk/leadership.pdf accessed 05/08/05.

Trustnet (2002) *Risk Governance in Europe* http://trustnetgovernance.com/. accessed 15/08/05.

Royal College of Nursing (2003), *Clinical Governance: An RCN Resource Guide.* Royal College of Nursing.

Royal Society of Medicine (2005) “Clinical Governance and audit”, *Clinical Governance Bulletin, http://www.rsmpress.co.uk/cgb.htm* accessed 15/08/05.

RPA Team (2005) *Appendix 4 Proposals for Additional Local Government Services* Consultation, http://www.rpani.gov.uk/consultdocu.pdf accessed 2/08/05.

RPA Team (2005) “Governance” in: *Review of Public Administration in Northern Ireland: Further Consultation,* http://www.rpani.gov.uk/consultdocu.pdf accessed 02/08/05.

Rudrum, J. (2002) *Corporate Governance Countdown*. www.accaglobal.com/publications/hsr/48/476253 accessed 02/08/05.

Rudrum, J. “Improved Corporate Governance in the NHS”, *Health Service Review*, 48.

Secretary of State for Health (1997), *The New NHS: modern. dependable,* Cm 3807, London: Department of Health.

Secretary of State for Northern Ireland (2005) *Priorities and Budget 2005-2008,* http://www.pfgbudgetni.gov.uk/fulldoc.pdf accessed 29/07/05.

Shaping Our Lives (2005) *Shaping Our Lives National Strategy for Service User participation*, London: Shaping Our Lives.

Sheaff, R. (2005)“Clinical governance: impact of National Service Frameworks on quality of care for mental health problems and coronary heart disease” National Primary Care Research and Development Centre, University of Manchester.

Shekelle, P. G. (2002) “Why don't physicians enthusiastically support quality improvement programmes?” *Quality and Safety in Health Care*, 11, 6.

Skelcher, C. (1998) *Appointed State: Quasi-governmental Organizations and Democracy,* Milton Keynes: Open University Press.

Skills for Care (2004) *Workforce Planning Toolkit,* 2nd Edition Leeds: Skills for Care (SfC).

Skills for Care (2005) *Leadership and Management Strategy,* http://www.topssengland.net/view.asp?id=494 accessed 25/01/06.

Small, N. (2005) “Quality of life and quality of service in social care” *Research Policy and Planning,* 13, 1 & 2.

Solace and ADSS (n.d.) *Statement on the Accountabilities of Chief Executives and Directors of Social Services in England* http://www.adss.org.uk/publications/other/accountabilities.pdf accessed 24/11/05.

SSI (Social Services Inspectorate (2002) “Expectations and Requirements of local councils in the governance of social work and social care services”, Annex A of *The Roles and Responsibilities of Directors of Social Services,* http://www.dh.gov.uk/assetRoot/04/01/13/24/04011324.pdf accessed 24/10/05.

Strategic Policy Making Team Cabinet Office (1999) *Professional Policy Making for the Twenty First Century*, www.policyhub.gov.uk/docs/profpolicymaking.pdf accessed 24/10/05.

Number 10 Strategy Unit (2002) *Risk: Improving government's capability to handle risk and uncertainty,* http://www.number10.gov.uk/SU/RISK/risk/home.html accessed 28/07/05.

Sullivan, H. & Skelcher, C. (2002) *Working Across Boundaries: Collaboration in Public Services* Houndmills Basingstoke: Palgrave Macmillan.

Sullivan, H. & Stewart, M. (2002) *Joining-up Governance - the coordination and integration of arrangements in Northern Ireland: Briefing Paper,* http://www.rpani.gov.uk/briefingpapers accessed 02/08/05.

Sullivan, H. (2004), "Power, participation and the practice of accountability", *Local Governance*, 30, 1, pp. 42-51.

TOPSS Northern Ireland (2000) *A First Class Service: Personal Social Services Training Strategy 2000-2003,* Executive Summary. Belfast: TOPSS Northern Ireland.

TOPSS Northern Ireland (2000) *Policy, Planning and Direction: Regional Training Strategy 2000-2003*, http://www.niscc.info/pdf/NI_Rts-doc1.pdf accessed 02/08/05.

Unrau, Y. & Grinnell, R. "The Impact of Social Work Research Courses on Research Self-Efficacy for Social Work Students" *Social Work Education,* 24, 6, pp. 639-651.

Waterson, J. & Morris, K. (2005) "Training in 'Social' Work: Exploring Issues of Involving Users in Teaching on Social Work Degree Programmes", *Social Work Education,* 24, 6, pp. 653-675.

Webb, S. (2001) "Some considerations of the validity of evidence-based practice in social work", *British Journal of Social Work,* 31,1, pp. 57-99.

Wells, J. (2005) "How well are we doing: a balanced scorecard approach to performance monitoring", Hertfordshire Partnership NHS Trust.