



'Actually getting together'Getting ahead of legislative change for inspection and regulation units

This story is about merging inspection teams from both health and social care who are concerned with the standards of care in residential and nursing homes. The rationale for this was to 'get ahead' of the national timetable for this shift and to provide a single service to service users, who often don't understand that if you're in a nursing home, you go to one regulatory body, if you're in a residential care home you go to another one - especially if they need to switch between the two.

This partnership developed following the White Paper, *Modernising Social Services* in 1998, which emphasised that Health and Social Care should be working more closely together. Stemming from this, the Care Standards Act 2000 required existing arrangements for regulating residential care homes be disbanded, and that from April 2002, a new national standards commission would embrace all regulatory functions in relation to residential care, that is, nursing homes, children's homes, adult homes.

In this area people were aware the change to a single inspection format for homes was on the horizon, so an independent report was commissioned to look at the viability of having a voluntary partnership, to prepare for these changes.

[Morag's viewpoint](#), **Manager of a Social Services Inspection Unit**

[Diane's viewpoint](#), **Manager of a Health Authority Inspection Unit**

[Stella's viewpoint](#), **Inspector in a Social Services Unit**, with a nursing background

[Sheila's viewpoint](#), **Acting Manager** of the new joint unit

[Mrs Smith's viewpoint](#), **Head of Nursing** in a group of private care homes

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Manager of a social services inspection unit - Morag's viewpoint

Morag tells how an independent report was commissioned to look at the viability of having a voluntary partnership between the health and social services inspection units, to prepare for the changes. The consultants then delivered their report at a presentation to all the staff of the units involved.

'... and it was at that point we encountered problems. There was a high level of resistance exhibited by people from Health. Looking back, I don't believe it was handled in the best way - in that those differences were recognised, but they weren't managed. The heads of the units were then given a remit to meet and implement the partnership. Now, that hasn't been successful, I have to say. And I think the key reason for the lack of success is that it lacked clear leadership. If you have resistance to start with, I think it's really important that there's somebody who's in the driving seat and seen to be impartial, co-ordinating the views, and sort of presenting some clear vision, keeping things on track and together. We were all of equal status with different accountability structures, so the meetings were fragmented and, I would say, disorganised. And that wasn't through lack of preparation on the part of some participants who tried very hard to get clear agendas, and keep to them. But it wasn't successful.'

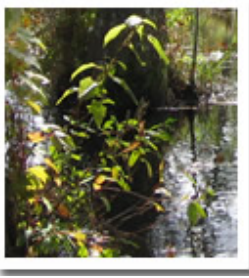


Morag found herself shocked at the way some of the resistance was played out in meetings: 'It's been an interesting experience because I've observed, I suppose, conduct that I didn't expect at that level.' She experienced the health unit head as disruptive in meetings: '...mobile phone going off through the meetings, arranging other meetings [during our meetings], being late..., not sticking to ..agenda [raising] personal issues [about].. rights, terms and conditions. Morag concluded that the fact that the partnership was in effect mandated [hyperlink to theory as in case 1 story 2] made a huge difference. In addition, it was not supported by any clear commitment or clear vision between the parties.

Morag reports that, after nearly a year, following requests from her colleagues and herself, it was agreed to appoint someone who could lead the partnership forward. Morag had thought the partnership would enable the area to prefigure the changes and it would be good to be at the forefront of that, to be piloting approaches and feeding into the Department of Health, influencing best practice. As a result of the difficulties she says: 'we've missed the boat on a lot of those pilots, which is really disappointing. But we did, a

few weeks ago, get accepted to test out some of the methodologies, so that's some success. And I'm personally involved in leading some of those projects, and other colleagues are leading the others. And I think that's very useful work to be taking place ahead of our merged unit.'

Reflecting on why some of the difficulties may have occurred, Morag feels there are very clear differences, culturally, between the way that the Health staff and the Social Care staff work. She sees Health inspection activity focusing on 'medical models of care', looking at clinical practice, and not she feels looking at individuals holistically.



'...they [Health inspectors] wouldn't have regard to their [service users] preferences and their individual needs. Doesn't take account of diversity. It's very depersonalised. The inspection function is carried out more like a ward round with teams of Health Authority staff going into homes, which I regard perhaps as intimidatory and inappropriate, considering we're going into people's own homes. It's a very formal, authoritative relationship. ...they [referring to nurses] are keen to defend their clinical and professional expertise, because they have had to strive quite hard to gain that recognition.'

She feels her unit's approach is very much trying to empower users, and trying whilst acknowledging their statutory authority, to empower providers, users and relatives as far as possible, and so develop a more equal relationship. She describes health authority staff who: '...see us as social workers who are unqualified, who have very feminine styles of working that are based on, and I say this in quotes, 'intuition', as opposed to any clear scientific, factual evidence; perhaps a bit sort of namby-pamby - you know, those sorts of stereotypes. And they might feel that their professionalism is diluted if they adopt some of our practice.'

Morag's approach to this difficult partnership work was to talk to colleagues outside of the meetings, to get their perspective and what they thought the blockages were and to look at strategies outside of the meeting, so how then to continue meeting and have more constructive dialogue. She tried to take it back to look at common purpose: 'Let's get some basics sorted, and if we can agree our purpose then we can maybe identify what the key objectives are. Where we are now, how far we need to move, and what we need to do to get there. That didn't work, although I believe I tried quite hard ... It was put down by the Health person. I think [they] probably saw it as a bit text book-y, and commented: "you're young and you're new to this", and "when you've been around as long as I have", and it was all

sort of rubbished, and I said, "well, I have been around doing this for ten years, and [they] sort of blustered a bit, but weren't really prepared to step outside of [their] rather defensive terrain, and look afresh at what we could all put on the table, and what we could work towards. A colleague said to me outside the meeting, "oh, well done" - but didn't say anything there. So I felt a bit like the Wicked Witch!



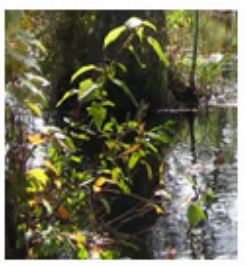
Finally Morag suggested a joint away day with all the staff. This was held and it was very successful. She says: 'everyone actually enjoyed it, which I think is the main thing because it actually got us working together. It was really nice working with Health inspectors and meeting them as people ... And I felt quite hopeful after that, and we said we'd have future meetings. But since then just the management meetings, [which] have continued not to be so productive.'

Morag comments: 'I don't understand how one person can have so much power. It fascinates me to analyse what it is that enables this person to be so powerful in the group. ...But I do think it's changing in fact, We're actually getting together and doing some good work, the rest of us; you know, this piloting. And I feel that certainly within my unit, staff morale has improved, because people are beginning to feel that we are working together.'

Manager of a health authority inspection unit Diane's viewpoint

Diane leads a health authority inspection unit working alongside several local authority units to integrate functions. Diane's story of the partnership charts the difficulties of working across registration and inspection in health and social care in the last couple of years. She sees this as a contrast to the positive joint work done before then: 'from 1991 to 1998 we did a lot. We set up a group to look at common procedures and documentation for dual registered nursing homes. We developed a lot and it worked quite well. We're still using some of the material.'

She recalls that following the White paper 'Modernising Social Services' in 1998 her health authority got funds agreed to 'look seriously' at the proposed joint inspection structures. But it seemed the Social Services Directors felt it was too soon to consider joint structures. The joint meetings continued but Diane felt there was not the same commitment to them from social services; they did not want to double their workload through doing what would only have to be done again once the Care Commission was in place.



Then in late 1999 a consultant's report to the Directors of Social Services 'got them exercised' and revived the joint work. It also

highlighted the major legal problems of an integrated unit. The report also brought staff concerns to the fore. It was hoped that the Department of Health would give its blessing to the area getting ahead of the timetable on integration, but despite a lot of work the DoH did not do this, sending no clear messages and no funding. Diane says: 'My team were pretty anxious, not wanting to be subsumed into social care as they are all nurses. It's two very different cultures. The team was keen to collaborate more if there was DoH approval, without it they feared there would be two re-organisations in 18 months, and their employment position put at risk and they didn't want that.'

There were a lot of human resource issues bound up in the shift to an integrated unit, such as an additional tier of management for the two professional groups. It was unclear how the overall head would be appointed, 'so it went quiet'. By early 2001 Diane judges the DoH was more focused on moving things forward, so it was felt there could be a recruitment, so an 'interim head' was appointed, but not without difficulty and grievance among staff.

Still the team of managers continues to meet: 'we're just ensuring we're each up to speed. We're responding to consultation documents and working on the DoH transition document, we each take an area.'

Reflecting on these events, Diane says: 'the health perspective, or side, has always been the minor, we feel on the periphery. It's a social care organisation and health has not much input. The team is only 4 nurses plus admin staff and in the new office it will be swamped. We already lost 2 people due to their concern. People feel vulnerable and bruised and this is an issue nationally too. People say they value nursing input and your role, then they talk about a 'social care' organisation and don't mention health. We feel we're losing. Even national figures at conferences start by saying health and then lose it half way through. It's the wrong message.'



maintained.'

On the positive side, she feels that nurses and social workers on the ground can sort things out. An awayday held with all staff 'worked really well. You wouldn't have known who was who. That is till a speaker in the afternoon ignored health. One person was so appalled she wrote to her MP. We need to see health professionals are really valued. But very little positive response has been

Diane feels the differing cultures of nurses and social care staff are key. Nurses take their own decisions and are professionally accountable, whereas for social care this accountability

is only just coming in. 'We're also gregarious and assertive and stand our ground. We are a team. But social workers are often out and working in isolation. We often talk about it how to bring the two together, difficult. I'm glad I'm at the end of my career!'

She also noticed that language was especially problematic: 'protocols was a new word for them, supervision means different things to us. The different professions need to recognise each others boundaries and expertise. Saying "it doesn't need a nurse to do that" just puts people's hackles up.'

Inspector in a social services unit – Stella's viewpoint

This Stella's viewpoint, she is an inspector in a social services unit, with a nursing background

Stella starts by talking about the way joint working happened before the initiative to unify the units across health and social services:



'The issues go way back over 10 years of meeting to try and set a common approach to dual registered homes and common standards generally. The first meeting I ever went to was quite surprising. I expected a set agenda and decisions but it wafted off to non-relevant issues and nothing progressed. It seemed that anybody could go and we all seemed to go once or twice and then get rather fed up with it! I had concerns because of my experience of jointly inspecting homes as I felt the 'enforcement' style adopted by the health people was not resident-centred. They came to a joint inspection once with 7 people and large groups were looking through people's bedrooms. They asked the manager to nominate a resident for interview and care records for inspection. I prefer to be more fly on the wall and to talk in some form to all residents, checking records that I choose rather than documents prepared for me. Their approach seems to be more 'red channel' than 'green channel' and my sense is this is not untypical of health inspection. They see the role of enforcement rather than our more subtle negotiation.'

Stella describes how the move to a unified unit was not too worrying as social services knew they would be the more numerous and dominate the process. But she also felt the barriers of professional practice would simply remain:

'Those barriers which mean we can't see any professional notes, nor be present when managers are interviewed about professional aspects. The expressed need to be supervised by a qualified nurse.'

She sums it up as about lack of trust. She heard a health inspector say this at a meeting: 'you need to be able to trust the people you are working with'. Her own experience of working directly with one or two health inspectors on a visit is mixed, both very good and very bad experiences. She feels getting into some actual joint work helps a lot. A colleague said 'it's scary but let's try it'. She feels if only they could do this it would break through a lot of the barriers. What did not seem to be acknowledged or addressed was that the health authority inspectors were being expected to change their working culture(ie from working in teams to working alone) and this may have been the source of some of the anxiety and resistance.



Stella felt the away-day did make progress and effort was made to help people work together in smaller groups. She recalls:

'It was a lovely day and a nice room - it made such a difference.

The first meeting on the consultants report was in a room with a long narrow table we were squeezed round. The layout meant that only certain voices were heard.'

Reflecting on the partnership work that has been done, Stella comments:

'We didn't look enough at our strengths and achievements. And we did have some; having those joint meetings, being on first name terms across the teams. We could have built on that, rather than trying to make a radical shift. I also think we didn't have a clear mission and so people lost confidence in the process. Were we a working human lab for the Care Commission? I think we were, but why? What would be the advantages to our clients of doing this? It wasn't clear what agenda was being followed. So people could only see the extra work involved and the meetings would detract from our work in homes and the benefits of that to residents. There was such a vacuum we didn't know what we were working towards. It seemed driven by managers not inspectors. By the unit heads' managers, with no involvement of staff. And the health inspectors seemed to me to be frightened.'

Head of Nursing – Mrs Smith's viewpoint

This Mrs Smith's viewpoint, head of nursing in a group of private care homes

Mrs Smith's background is of long experience in the NHS and in South Africa as nurse and midwife and nurse/midwife tutor. 'All my career in care and nursing.' She is keen to work with professionals like herself and benefit from their expertise.

She comments on the changes in the inspection process:

'Because of the new Care Standards they are trying to put their house in order and so it's pressure on us. 'There is no point in being defensive, we have to see the objective standards

of the inspectors - but they are only human ...'

She described the situation in Bexley where they already have a joint unit and how much better it is to have it all on one day and less duplication of effort. In her local area she feels 'there are differing opinions. With dual registered homes we get conflict sometimes.. so we need to all work together and to understand each others areas of work.'



In discussing the coming shift to joint inspection units for all areas she commented:

'Watch this space! We need the watchdogs, ones who are clear

and tell us what's what and have the tools and then we can work with them. I expect those who come will have adequate knowledge. How will they support us? We'll wait and see.'

She and her colleague in non-clinical management agreed that it would only become clear in the interpretation after the first round of inspection and feared a loss of 'room to manoeuvre' with national standards as they have at present. The existing relationship with the inspectors was seen as very valuable.

Her colleague comments : 'We can phone and say we're planning to do this, what would your reaction be, how would you see that? If there is a complaint we can check out with the unit their view and get advice on how we should handle it. The unit always asks people if they have informed the home, so we work in partnership on it.'

Acting Head of joint inspection unit – Sheila's viewpoint

Sheila's viewpoint, acting head of joint inspection unit (previously a unit head in social services)

Sheila acknowledged that building unified inspection between the health authority and social services was always going to be difficult: 'It appeared to be harder for health - they would be a minority in the new unit and perceived integration as a threat to their professional status. This was a national issue in the transfer of health authority units to the National Care Standards Commission (NCSC). I tried to reassure the staff locally, at meetings and in written statements. I stressed to all the staff that mutual respect was essential, that we needed to learn from each other, accepting that each unit brought particular skills and experience and had stronger and weaker areas'.

Sheila believed that behind the new rhetoric of partnership there was a very old story of what happens in organisational change: people protect their own positions and pursue their individual agenda. The challenge was to demonstrate that the common agenda and collective interest were bigger. She described how She and her counterpart in the health authority -

as the two candidates for the overall manager position - acknowledged together early on that neither would relish working under the management of the other and would take early retirement if offered. That did not happen. The health unit maintained a high level of challenge to the planned changes. 'It's hard to see how this could have served their best interests ... holding back development towards the new local structure of the Commission was not the way to protect or promote your interests in the new organisation... Most of us saw the objective of a well planned and smooth transfer as being in the wider interests of the authorities and the service users and providers'.

She went on:

'The project was steered by the directors from the authorities. Although they made their intentions clear from the start, statements were made to all staff about imminent changes before these were thought through in detail. The result was missed target dates and long delays, which undermined those supportive of integration and encouraged the sceptics. Questions from staff about detailed implications of the proposals could not be answered. The appointment of an overall manager came a year later than originally intended. The definition of the role and my managerial authority was questioned and challenged by health. The directors issued clarification, but in the end I had to be rather philosophical about it. A change of this kind requires the good will of key people; if that's not forthcoming, you do your best without it. The real issue was how far and how quickly people wanted to move towards the new system and have a chance of influencing its development'.



Sheila was keen not to lose sight of the achievements of the partnership:

'In fact, in spite of complex options put forward in a feasibility study, the final practical arrangements were simple and easily agreed and implemented. There was a lot of support for the initiative in the local authority units, which would not be diverted by a reluctant minority. Although Department of Health (DOH) guidance encouraged unified management arrangements, few other areas went down that road. The benefits to our organisations became clearer the closer we got to the transfer date. Had the new area office premises been available in advance of the transfer (as had been hoped), the scope for more integrated working would have been greater. Nevertheless, through joint planning and co-operation, our authorities were better prepared. Our transition action plan was regarded as a model for others to use. The management team functioned well in addressing common issues and there were also opportunities for staff to work together in responding to the DoH guidance and testing draft procedures. Unified management enabled

more effective communication and collaboration with the DoH and NCSC, which ultimately enabled the transfer to be better planned and smoother than it might have been.'

[Issues in this story](#)

While since this story was researched there have been yet more changes in the inspection regimes for health and social care homes, this story nonetheless highlights some critical issues for partnership working across health and social care boundaries:

- the potential diversion factor of a key resister - but what power do they really have if they are isolated ? The movement was achieved when all the actors were brought together [widening the circle - Axelrod]
- the impact of not having early enough leadership - the need to focus effort and for someone to help the group deal with issues early on
- the importance of purpose and its relation to the service users, especially where staff are not front-line deliverers. Here the actors each worked within their own assumptions about their work and its purpose and philosophy
- that the positives flowed from involving all the staff not just managers.
the limits of a 'zero sum' view of power
- how issues of fear and anxiety come to the fore, especially when core matters of how people perceive their own professionalism are at stake
- how despite a common understanding that a cultural gulf existed and had to be bridged, the important thing is to have the tools of dialogue to deal with it